Basic Interviewing Skills for Medical Students

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Introduction

There are three primary purposes to this booklet. The first is to introduce you to the basic tenets of professionalism. The second is to provide an introduction to the general orientation toward patient care that we teach here at the FSU College of Medicine. This is a patient-centered form of care, with an emphasis on the biopsychosocial model of health and illness. The third purpose is to provide an introduction to some of the specific skills necessary to conduct effective patient interviews. Although these three areas may seem distinct from one another, in fact they are deeply intertwined. We strongly encourage you to approach these three domains in an integrated fashion.

You will have many opportunities to practice the skills described in this booklet. For example, we frequently use role-playing exercises to give you a chance to practice the skills that are necessary to conduct effective medical interviews. In these exercises, you will have the opportunity to interact with your classmates, medical school faculty, and trained “standardized patients” in pre-defined scenarios. Although this might initially feel awkward, research demonstrates that these types of learning experiences can be very valuable for those who take them seriously. The more you practice the more effective you will be when you do the “real thing.”

You will also be expected to behave in a professional manner from your first day as a medical student. It is important that you take this aspect of your education seriously. Professional behavior is fundamental to good medical practice, and the time to begin acting professionally is now.

Your understanding of the skills and approaches outlined in this booklet, and your ability to use them, will be assessed frequently throughout your training as a student at FSU College of Medicine. We are confident that these skills and approaches to the practice of medicine will help you become a confident and effective interviewer.

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Professionalism and Ethics

Professionalism for Medical Students

Professionalism can be understood as the individual commitment to uphold the standards of behavior and normative values associated with the satisfactory performance of a particular occupation. To be a good physician, in other words, one must act according to the values and standards of professional medicine. Clearly, certain aspects of professionalism are widely shared across professional occupations, including a commitment to ethical behavior and a commitment to delivering quality services or products. Other aspects of professionalism, however, are unique to each particular occupation. Physicians thus have overlapping, but not identical, professional requirements with members of other professional groups.

Professionalism among physicians is regulated through professional societies, licensing boards, and other institutions. These institutions serve an important function because they enforce what can be considered a contract between the individual physician and society as a whole. The essence of this contract is that society grants physicians certain rights and privileges, and in return physicians agree to perform certain duties and behave in certain ways. For instance, physicians have certain legal privileges, such as the right to prescribe medications, and they are therefore expected to handle this privilege responsibly (e.g., be informed about available medications and their potential side effects, provide prescriptions only to patients under their care who would benefit from them, etc.). All such privileges and benefits should be understood as part of the professional contract that physicians voluntarily make with society when they decide to enter their chosen field. As a result, these benefits imply an obligation to act professionally on the part of each physician. To do otherwise is not only to violate the norms of one’s chosen field, it is to violate the contract one has made with society as a whole.

This applies to medical students as well. Over the past two decades the topic of professionalism has become an increasingly important part of medical education. Medical schools and residencies across the country now teach professionalism as a standard part of their educational mission. The American Association of Medical Colleges, for example, states that all medical students should be knowledgeable, skillful, altruistic, and dutiful – meaning that students should be engaged in advocacy, outreach, and other efforts to improve the non-biological determinants of health. The Accreditation Council for Graduate Medical Education is the body that oversees all residency training in the U.S. They state that all residents must be taught and assessed in the area of professionalism, which they describe as including: respect; compassion; integrity; responsiveness to the needs of others; altruism; commitment to excellence; sound ethics; and sensitivity to culture, age, gender, and disabilities.

We encourage you to approach the topic of professionalism in a dynamic manner. Becoming a professional is about more than simply conforming to a set of rules. Instead, it is a continual process of evolution in one’s understanding, acceptance, and integration of the norms and values that make a good physician. Professionalism thus implies that we regularly reflect upon our own personal conduct and attitudes, our relationships with
our patients and colleagues, and how we perform our responsibilities. Professionalism is made manifest in how we talk to faculty, staff, peers and patients; whether we dress in a way that shows respect for others whose standards of modesty may be different from our own; whether we are well prepared for a small group session whose success is dependent upon active group participation; how we handle conflicting opinions; what we do when we are faced with an ethical dilemma; how we behave in the face of difficult situations; and numerous other situations that occur every day. When properly understood, professionalism acts a guide and resource that we can draw on in order to shape our behavior, thoughts, and character. As one matures as a practitioner, the concept of professionalism, what it means, and how it guides both the practice of medicine and our own personal conduct deepens and matures as well.

In order to facilitate this process of growth, many educational activities will occur throughout the career of every medical student and physician to help individuals develop increased professionalism. Professionalism in medical students is assessed every day by faculty, staff and peers in both formal and informal ways. The feedback we provide and receive regarding professional behavior may also be formal or informal, but it needs to occur. We all need to be encouraged to do more of what we do “right” and less of what we do “wrong”. Medical students should expect and even seek out feedback on their professionalism. Feedback and the pursuit of improvement in our professional behavior supports personal satisfaction, collegiality, productive learning environments, interdisciplinary teamwork, and most importantly, good patient care.

Basic Ethical Principles

The relationship between ethics, morality, and professional behavior is a complex topic. For our purposes, there are three general domains to keep in mind:

- **Professional ethics**

  Professional ethics can be understood as the basic ethical principles that guide a physician’s professional behavior. Various professional boards and organizations have codes of ethics that can be used as a guide for understanding professional ethics, including the American Medical Association’s Principles of Medical Ethics and the Charter on Medical Professionalism, a collaborative effort of a variety of professional groups. These codes are not the final word on what is and is not ethical from a professional standpoint, but they are extremely important guides to professional behavior. Physicians are expected to follow these codes in order to remain members of the organization in question, and violating these codes can carry serious professional consequences.

- **Personal morals**

  Each of us has a set of personal beliefs about what is and is not moral behavior. Most people agree that certain types of behavior are immoral – for example, all of us presumably believe that murder is wrong – but there can be substantial differences of opinion on other issues, such as abortion, the use of illegal drugs, or premarital sexuality. It is extremely important to recognize that your patients may have different ideas than you do about the morality of certain forms of behavior. It
is not our job as physicians to pass judgment on our patients – it is our job to assist them in maintaining their health.

• Legal obligations

Physicians, like everyone else, are obligated to follow the law. Failing to do so can carry serious consequences. Furthermore, physicians are sometimes sued by patients or their relatives and as a result can be subject to sanctions. However, this does not mean that physicians should practice defensive medicine. Practicing medicine in a manner that is intended to minimize the risk of lawsuits can lead to practicing bad medicine. Moreover, it does not necessarily reduce the chance of being sued. In fact, research has shown that defensive medicine, which typically involves excessive procedures, leads to increased lawsuits.

Professional ethics, personal morals, and legal obligations typically overlap to a substantial degree, but they are not reducible to one another and at times they can be in conflict. In particular, professional ethics and a physician’s personal morality may not always correspond. Therefore, it is important to find a way to reconcile one’s deeply held personal beliefs with the professional ethics necessary to be a practicing physician.

The Four Core Ethical Principles

At the heart of professional ethics lay four core concepts. These four concepts can be recalled using the mnemonic “Anywhere But New Jersey”. They are:

1. **Autonomy**
   This is the principle that patients should always have the freedom to determine the course of their own care, including acceptance or refusal of further testing or treatment. It is deeply connected to the idea of informed consent.

2. **Beneficence**
   This is the principle that it is the physician’s responsibility to contribute to the well-being of the patient and to always do what is in the best interest of the patient.

3. **Non-maleficence**
   This is the principle of not inflicting, or minimizing, harm to the patient. Non-maleficence tells practitioners to “First, Do No Harm”, and this serves as a reminder that the side-effects of a treatment plan must be factored into recommendations.

4. **Justice**
   This is the principle that all patients should be treated equally. If a patient is to be treated differently, then the physician should be able to offer a rationale that explains the necessity and appropriateness of treating this person differently than others are treated. Some argue that the principle of justice implies an obligation to provide services to those who cannot otherwise afford them.
The Importance of Reflection and Self-Assessment in Professional Development

What are Reflection and Self-Assessment?

A large portion of medical learning occurs in response to clinical experiences. This experiential learning is facilitated and enhanced when students reflect on their experiences and self-assess. “Reflection” refers to “careful thought or consideration about a particular patient, situation or series of events.” “Self-assessment” begins with the act of reflection, but also includes a willingness to honestly determine the value, benefit, or quality of one’s actions or behavior.

Why are Reflection and Self-Assessment Important?

Reflection and self-assessment allow the student – or physician – to process clinical experience, critique it, and improve his or her behavior in subsequent similar situations. Reflection and self-assessment are therefore important skills to learn so that you can constantly be improving other skills.

This is a life-long process. Reflection and self-assessment are the behavioral foundation for life-long learning, since they promote continued growth and development by encouraging students and physicians to recognize and address their own personal weaknesses and limitations. Perhaps most importantly, reflection and self-assessment lead to greater self-awareness. Self-awareness, or knowledge of oneself, is important in a wide variety of situations that students and physicians typically face. When students choose a medical specialty, for example, those students who approach the process with self-awareness will usually make better choices. In the clinical setting, recognizing one’s own personal biases and prejudices and making purposeful attempts to neutralize their impact on the care of patients is clearly a constructive use of self-awareness. If left unrecognized and hidden from consciousness, these biases can influence everything from assumptions we make about patients based on their race, gender, age or dress, to advice we give patients about which treatments work and which do not.

One of the most important benefits of reflection and self-assessment is that it allows us to know what we do not know. Many medical students think they already know what they need to know and what they do not need to know. This is a mistake, and it leads to many problems. Actively practicing reflection and self-assessment helps us to understand the limits of our own knowledge.

Know thyself. 
- The Oracle of Delphi
How are Reflection and Self-Assessment Skills Developed?

Reflection and self-assessment are skills that must be developed through practice. Whenever possible, students should take the opportunity to reflect and self-assess, reviewing what they did, how they did it, and what the outcomes were. This sets the stage for the student and/or the teacher to consider means for improvement. In addition, when a teacher recognizes errors in the student’s self-assessment, the teacher should diplomatically correct them. When done skillfully, teachers that foster accurate self-assessment in students are assisting the student to develop a valuable skill and nurturing a collaborative relationship with the student.

It is therefore important that students take the time to practice reflection and self-assessment. Although medical school is an extremely busy time, giving yourself adequate time to reflect on your experiences will help you become a better physician. The following characteristics are associated with developing these skills:

- Recognition that in medicine it is impossible to know everything about everything. All students and physicians still have much to learn.
- Willingness to take responsibility for one’s own learning and be an active learner.
- Commitment to personal improvement.
- Awareness of one’s own strengths and weaknesses.
- Awareness of one’s own biases and emotional responses to various activities.
- Focus on learning; not obsessed only with grades.

Self-Reflective Writing

A number of medical schools have initiated reflective writing activities for students in order to enhance reflection and self-assessment skills. In these activities, students write about their subjective responses to medical issues, patient stories, and treatment experiences. Reflective writings also allow medical students to learn from one another and to know that they are not alone. When these writings are shared, students can better understand the difficult issues they face as they learn to practice medicine, including their emotional responses to patient illness and death, the fear of making a mistake, and the discomfort many students feel when confronting uncertainty. Reflective writing is also helpful in promoting learning and developing one’s skills. By writing about your experiences, reflective writing helps you to increase your personal understanding of complex issues. As a result, reflective writing is being emphasized by the Association of American Medical Colleges as an important method for learning. As a medical student at FSU College of Medicine, you will have multiple opportunities to practice self-reflective writing. However, we also encourage you to take the time to regularly write about your experiences in a personal diary or journal. If you do so regularly, you will find that it is extremely rewarding.

"All learning comes from experience, and reflection on that experience."
-John Dewey
**Giving and Receiving Feedback**

In addition to reflecting upon one’s experiences and ensuring that one engages in professional behavior, it is also important that a physician be able to receive constructive feedback from his or her colleagues in order to improve or correct skills or behavior when needed. Likewise, a physician has a professional responsibility to effectively provide feedback to his or her colleagues. Opportunities for giving and receiving feedback will begin very early in medical school and will continue throughout one’s medical career.

Feedback is a way of helping other people to consider changing their behavior. It is communication to a person or a group which gives them information about their effect on others. In other words, feedback is a way of giving help. It is a corrective mechanism for individuals who want to learn how well their behavior matches their intentions. It is also a means for determining one’s impact on others.

**Criteria for Giving Feedback**

1. **It is descriptive and objective.** Comment on observable behavior and consequences. Avoid subjective interpretations or judgmental language. This will make the communication flow more easily and reduces the possibility of a defensive response.

   Instead of: “The patient mentioned several times that she is experiencing a lot of stress with her children. You didn’t notice or care that she was upset.”

   Try: “The patient mentioned several times that she is experiencing a lot of stress with her children. Rather than continuing with your questions about her respiratory symptoms, this would have been an opportunity to acknowledge her family concerns.”

2. **It is descriptive and specific.** Provide observations on specific aspects of performance. Avoid vague or generic feedback, which provides the individual with little information on ways to improve performance or what aspects of performance should be maintained.

   Instead of: “You did a great job in that interview.”

   Try: “You covered all of the appropriate questions related to the patient’s current cardiac symptoms, and you also asked about her worries and concerns related to these symptoms. This provided you with helpful information about the patient’s family history of cardiovascular disease.”
3. **It takes into account the needs of the receiver.** The goal of giving feedback is to help the receiver perform better. It can be destructive when it serves only the needs of the feedback giver and fails to consider the needs of the person on the receiving end.

4. **It is directed toward behavior that the receiver can do something about.** Frustration is only increased when a person is reminded of shortcomings over which she or he has no control.

5. **It is solicited, rather than imposed.** Feedback is most useful when the receiver can formulate a question which those observing him or her can answer.

6. **It is well timed.** In general, feedback is most effective when delivered at the earliest opportunity after the behavior has occurred, although this can vary depending on the person’s readiness to hear it and support available from others.

7. **It is checked or verified to ensure clear communication.** One way of doing this is to have the receiver rephrase the feedback to see if it corresponds to what the sender has in mind.

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**The good physician**

*knows his patients through and through and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.*

--Francis Weld Peabody
The Biopsychosocial Model and Patient-Centered Care

The Biopsychosocial Model

The biopsychosocial model proposes that health and illness are affected by the interaction of biological, psychological, and social factors (see Figure 1). Biological factors include genetic makeup, disordered biochemical and neurophysiological processes, cellular dysfunction, and exposure to pathogens. Psychological factors include thoughts (cognition), feelings (emotion), and behavior. Social factors include societal norms and values, culture, and interactions with friends and family. A tremendous amount of evidence suggests that health and illness are shaped by the interaction of these three factors.

Figure 1. The biospsychosocial model of health and illness.

The biopsychosocial model was originally proposed by physician George Engel in an influential article published in *Science* in 1977. It arose out of a growing dissatisfaction with the dominant model of disease at the time: the biomedical model. The biomedical model held that disease resulted solely from the derangement of underlying physical mechanisms, and gave little or no attention to the role of psychological and social factors. Under the biomedical model, health was defined simply as the presence or absence of disease.

In contrast, the biopsychosocial model characterizes health on a continuum defined by an individual’s physical and mental status, functional ability, and psychosocial well-being. Further, the biospsychosocial model differentiates disease from illness. Disease is defined as a biological process, whereas illness is defined as an individual’s experience with a disease. This is an important distinction, because a person may have a disease, but not feel ill (or vice versa).
The biopsychosocial model posits that health and illness stem from the interplay of biological, psychological, and social factors, and thus all three must be taken into account when making a diagnosis and selecting an appropriate treatment plan. Let’s take an example:

**Case Example of JW:**

A 53 year-old man (JW) presents in the emergency room with chest pain. After further evaluation, it is determined that he has had a heart attack. JW has a very demanding job that is accompanied by high levels of stress and frequent travel. He smokes to deal with his stress, eats poorly, and rarely exercises. He is married and has two children, but sees his family infrequently because of his job. He and his wife have been fighting more than usual and he feels distant from his children. He was recently diagnosed with hypertension and also is overweight.

How can a biopsychosocial approach help us understand JW’s current health status and develop an appropriate treatment plan?

JW’s current health status is a function of the interplay among all three domains:

**Biological:** Prolonged exposure to stress hormones and cigarette smoke have damaged his heart and arteries

**Psychological:** He used maladaptive coping strategies and unhealthy behaviors (smoking, poor diet, physical inactivity) to deal with the stress

**Social:** He endures a stressful work environment and has strained relationships with his wife and children

In deciding on a treatment plan for JW, it will be important to address factors associated with all three areas to help restore his health and to prevent a second heart attack. This may include prescribing medication to reduce his high blood pressure, encouraging him to quit smoking and engage in stress management, and providing counseling to improve his family relationships.

In order to provide the best care for your patients, it is important to consider factors from all three domains when making a diagnosis and deciding upon the course of treatment. An integrative approach to medical care that involves the entire health care team (physicians, nurses, psychologists, dieticians, social workers, etc) is essential in this process.
Patient-Centered Interviewing

Consistent with the biopsychosocial model of health and illness is the practice of patient-centered interviewing and clinical care. In fact, patient-centered interviewing is the primary means by which physicians obtain a patient’s information represented within the three components of the biopsychosocial model.

Patient-centered interviewing describes a specific approach to interacting with and eliciting information from patients. Beyond the biological disease process, patient-centered interviewing allows the physician to evaluate the broader experience of illness for a patient. This interviewing style provides an opportunity for physicians to better understand many aspects of the patients’ illness experience, including their symptoms and the impact these symptoms have on them, their families, and their physical, psychological, and social functioning. This approach also attempts to capture patients’ attitudes and approaches to different treatment options as well as the positive and negative impacts that different treatments may have on them (e.g., financial impact, concerns about efficacy, side effects, and so on).

Characteristics of Patient-Centered Interviewing:

- Focuses on disease AND illness experience, rather than exclusively on disease process.
- Allows patients to express what is most important to them.
- Recognizes and promotes self-sufficiency, responsibility, and autonomy of patients.
- Uses open-ended questions to elicit patient’s perspective on illness, treatment, and other psychosocial issues or concerns.
- Tailors questions, terminology, and counseling based on the individual patient’s context and circumstances.
- Demonstrates empathy and a non-judgmental attitude by the physician toward the patient’s experiences.
- Allows patient and provider to collaborate and compromise on the meaning of symptoms, causes of illness, goals of treatment, and different treatment options.
- Provides opportunities for disease prevention and health promotion.
Why is a Patient-Centered Approach Important?

A thorough clinical interview often provides more information necessary for accurate diagnosis, appropriate treatment, and disease prevention than the physical exam or laboratory studies. Therefore, the value of an accurate and complete interview should not be underestimated. A physician could stop her clinical interview after determining the presence or absence of particular symptoms that point to a specific diagnosis and corresponding treatment plan. However, failure to inquire about the psychosocial aspects and illness experience of a patient’s presentation may leave the physician with inadequate information and could lead to suboptimal clinical outcomes.

It is important that the physician ask about the psychosocial components of a patient’s illness because these issues can influence a variety of factors, including:

- What and how much additional clinical information they choose to share with their physician.
- Whether or not they seek additional care in the future.
- How they evaluate the effectiveness of treatment and potential side effects.
- The strength of the patient-provider relationship.

Furthermore, patient-centered interviewing has been associated with:

- Greater patient satisfaction with their physician and the clinical care received.
- Improved patient adherence with treatment.
- Better patient recall, understanding, and knowledge of information discussed during clinical encounters.
- Better health outcomes related to diabetes, hypertension, cancer, post-operative recovery, and other conditions.

Listening and Narrative Medicine

Consistent with both the biopsychosocial model and with patient-centered interviewing is an approach to medical practice called “narrative medicine.” This term was coined by an internist named Dr. Rita Charon. It refers to the intentional effort to gain a deep understanding of a patient’s story through active listening and other means. One of the most common complaints patients have of their doctors is that “they don’t listen.” Medical students are often surprised to hear this, because they asked all of the relevant questions and wrote down all the answers. But the true story of a person’s illness goes...
far beyond the simple facts of where, when, how, and so on. Good medicine is not only about gathering all the pertinent facts, but also about developing an understanding of the patient’s illness and the story behind it through active listening skills. This understanding necessarily entails knowledge of the patient’s reaction to their illness, their fears and concerns, their methods for coping with their change in their health, the responses of their family, and similar issues.

One of the difficulties of being a physician is that one is called upon to provide advice, guidance, and support in situations of which one has little personal knowledge. Although patients expect their physician to be technically competent, what they truly desire is more than technical competence – it is someone who will understand the situation they are in and help them get better. Listening makes this possible. When one is moved by the patient’s story, one feels empathy for his or her situation and the subtle aspects of caring come out. This helps the physician avoid becoming a judgmental interrogator, and instead become an ally. As Dr. Charon has said, “Narrative medicine is a medicine practiced with the skills to recognize, absorb, interpret, and be moved by stories of illness.”

A substantial amount of research exists to support the observation that patients have a sense of what is wrong with them and what will most benefit them. There is also a growing body of research that shows that when patients are asked to provide a full narrative of their condition, they tend to have higher adherence and better outcomes. As a result, in some medical centers patients with life-threatening conditions are being asked to write their own narratives as part of their therapy. However, there are many other options for incorporating narrative medicine into medical practice. The simplest is to simply be quiet and listen. Once the patient knows that you are interested and not likely to interrupt, he will often begin with a flow of important information. One can then ask some probing questions – how has this affected your life? What has it been like to be living with this? How have you handled it? The most appropriate response is often simply direct eye contact, nodding of the head, and an occasional, “Go on.” The most important “technique” is simply listening and watching attentively.

Narrative medicine is not something that can be quickly learned. Like being a writer, excellent listening takes much practice. This type of practice never ends, because each patient’s story is different. Physicians who practice narrative medicine do not tire of being a physician, in fact, they are constantly rejuvenated by it. Most importantly, patients benefit by having an ally who truly understands them and their needs.
**Patient Autonomy and Informed Consent**

As mentioned previously, one of the core ethical principles of medicine is the doctrine of *patient autonomy*, which is the notion that patients have the right to make their own decisions about their medical care. In order for patients to be able to make good decisions, however, physicians must ensure that they have provided the patient with the necessary information to do so. Informed consent is often described as a process of communication between a patient and physician that results in the patient's authorization of a specific medical intervention. However, informed consent should be about more than getting a patient to sign a written consent form. It is better described as the process of communication between a physician and a patient or patient’s surrogate that results in the patient's understanding of a proposed treatment, tests, or diagnosis and its major implications.

That is, informed consent is a process that empowers the patient or surrogate with enough pros, cons, and alternatives to make an informed decision about the given treatment, tests, or diagnosis. It often includes 1) the patient's diagnosis, if known; 2) the nature and purpose of a proposed treatment or procedure; 3) the risks and benefits of a proposed treatment or procedure; 4) alternatives – regardless of their cost or the extent to which the treatment options are covered by health insurance; 5) the risks and benefits of the alternative treatment(s) or procedure(s); and 6) the risks and benefits of refusing all treatments or procedures. Once explained, the patient should have ample opportunity to ask questions, and have time to make a decision based on her understanding.

In essence the following four conditions must be present:

1. The patient or surrogate(s) must have the *capacity* to make decisions.

2. The provider must disclose enough information about the treatment, procedure, tests, or diagnosis to include risks and benefits as well as alternatives with approximate likelihoods of the risks and benefits.

3. The patient or surrogate(s) must demonstrate comprehension and have time to clarify any vague points or ask questions.

4. The patient or surrogate must voluntarily grant consent (usually in writing) without coercion.

Informed consent is both an ethical obligation and a legal requirement that is clearly addressed in statutes and case law in all 50 states. It is important and appropriate to document the informed consent process, and this is often done in writing. Most importantly, informed consent is central to the practice of good medicine. As a physician, your job will be to help your patients. In the end, however, your patients are the ones who know what is best for them. Informed consent is a necessary component of their ability to make decisions for themselves about what is best for them.
Communicating With Patients

Communication is at the heart of the medical interview. This section is devoted to specific skills designed to promote an efficient, thorough, and patient-centered medical interview.

**Agenda Setting**

One of the most important parts of the interview is *setting the agenda*. As Cohen-Cole (1991) notes, “surveying problems allows the patient and the physician to get an understanding of the medical landscape and then decide which territory to explore first. This will increase the efficiency of the interview and allow the patient and physician together to make informed decisions about how to spend the available time.”

However, many patients lack the ability to introduce physical and psychosocial problems during their medical visit, even when the clinician directly asks about the reason for the visit. Observational research demonstrates that:

1. Patients experienced many important physical and psychosocial problems that they never report to the doctor: 56% failed to raise one or more physical problems they judged to be important in their medical visit. 60% failed to raise one or more psychosocial problems they judged to be important in the visit.

2. The vast majority of patients want to introduce important problems in the medical visit. When patients successfully introduced their most important problem, only 30% did so initially. On average, patients introduced their most important problem as the third problem.

Data from this and other studies indicate that physicians routinely miss important symptom information unless they take a deliberate approach to eliciting the patient’s reason for the visit. Two useful deliberative approaches are:

- **Exhaustive questioning**: After patients provide their initial concern or reason for the visit, continue to ask, “Is there something else you would like to address today?” until they have identified all concerns before continuing with the clinical interview.

- **Patient activation**: Request that health coaches and/or family members work with patients before the visit to develop a list of concerns the patient wants to address in the visit. Research shows that this strategy dramatically increases the effectiveness of the medical interview without increasing visit length.

Getting to a good visit outcome requires the physician to identify the range of important symptoms and concerns the patient brings to the visit. Doing so requires the physician to employ deliberate interviewing skills at the beginning of the visit before proceeding with diagnosis and treatment.
**Asking About Symptoms: The “Sacred Seven Dimensions”**

At the heart of the medical interview is the effort to elicit as complete a description as possible of the problem(s) facing the patient. One important part of this process is gathering data about the patient’s symptoms. Questions about symptoms can be divided into seven broad dimensions:

<table>
<thead>
<tr>
<th>History of Present Illness (HPI) characterizing dimension</th>
<th>Question(s) to elicit information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodily location</td>
<td>Where is the pain? Can you show me where it hurts?</td>
</tr>
<tr>
<td>Radiation</td>
<td>Does the pain seem to move to any other location?</td>
</tr>
<tr>
<td>Quality</td>
<td>What does this pain feel like? Can you describe the pain?</td>
</tr>
<tr>
<td></td>
<td>(Only offer examples if the patient does not understand the question. In response to “what do you mean?” you might say “Sometimes pain is described as sharp or throbbing, how would you describe your pain?”)</td>
</tr>
<tr>
<td>Quantity/severity</td>
<td>On a scale of 0 to 10 with 0 being no pain and 10 being the worst pain you can imagine, how would you rate your pain?</td>
</tr>
<tr>
<td></td>
<td>Note: this is a national, validated scale used verbatim. For non-pain symptoms, ask “How bad is the problem?”</td>
</tr>
<tr>
<td>Timing: a. Onset</td>
<td>a. When did this problem start? OR, How long have you had this problem?</td>
</tr>
<tr>
<td>b. Duration</td>
<td>b. When you have the problem, how long does it last?</td>
</tr>
<tr>
<td>c. Frequency</td>
<td>c. How often does this problem occur?</td>
</tr>
<tr>
<td>d. Progression</td>
<td>d. Has this problem been getting better or worse? Tell me how it is changing.</td>
</tr>
<tr>
<td>Setting/context of symptom at time of onset</td>
<td>What were you doing the first time you had this symptom?</td>
</tr>
<tr>
<td>Modifying factors:</td>
<td>a. What makes the problem worse? Ask “Something else?” until answer is no.</td>
</tr>
<tr>
<td>a. Aggravating</td>
<td>b. What makes the problem better? Ask “Something else?” until answer is no.</td>
</tr>
<tr>
<td>b. Relieving</td>
<td></td>
</tr>
<tr>
<td>Associated symptoms</td>
<td>Have you had any other symptoms? (If answer is no ask about symptoms that may accompany chief concern: Have you had a fever?)</td>
</tr>
</tbody>
</table>
Assessing the Context of Illness and its Impact

In addition to gathering data about a patient’s symptoms, it is also important to investigate the social context of the illness and determine the impact of the illness on the patient. In some cases, a patient may be more concerned about the impact of an illness on his or her ability to function in a particular situation than on the illness itself. A college football player, for example, may be more worried about missing the next game than about the knee pain that brought him to your office. An obese husband may be more concerned about his wife’s opinion of his weight than about the possibility of a heart attack.

Areas that can be explored to determine the social context of an illness include the following:

- Personal and family history
- Functional history
- Social relationships
- Daily environment: work, school, etc.
- Daily routine
- Financial situation and other available resources

Among other areas, illness can affect the following:

- Self-image and self-concept
- Family dynamics
- Activities of daily living (ADLs): ability to perform basic personal care, including bathing, dressing, grooming, mobility, continence, and feeding
- Instrumental activities of daily living (IADL’s): ability to manage home life for oneself, including phone use, medication use, shopping, cooking, cleaning, finances, and transportation
- Advanced activities of daily living (AADL’s): ability to complete activities that make life meaningful for an individual, including activities related to recreation, church, school, and work
Exploring the Meaning of Illness From the Patient’s Perspective

In addition to gathering data about a patient’s symptoms and investigating the social context and impact of an illness, it is also important to explore the meaning of the patient’s illness from his or her perspective. Among other benefits, this will allow you to discover new and potentially important information, build rapport with the patient, and make recommendations that make sense to the patient and that he or she is more likely to follow. Examples of questions that can help you explore the meaning of the illness from the patient’s perspective include the following:

- What do you think has caused your problem? How?
- Why do you think it started when it did?
- How does it affect you?
- What worries you the most?
- What kinds of treatment do you think you should receive?
- Why did you decide to come in for this problem now?

Determining the social context of an illness, its impact, and the meaning of an illness from a patient’s perspective will require you to have excellent observation and listening skills. It will also require you to approach the medical interview in a culturally sensitive manner.

Observation and Listening Skills

An excellent clinical interview is not just about asking the “right questions”, but it also involves carefully observing the patient’s behavior and intently listening to his or her story. Observation and listening skills are extremely important in the clinical setting. To be an effective interviewer, it is important to slow down, relax, and observe your patient’s nonverbal behavior. Nonverbal communication is usually outside of conscious awareness, and the meaning of different types of nonverbal behavior can vary tremendously according to culture, gender, age, and other variables. There are three basic components to nonverbal communication:

1. Visual/Eye Contact

What is acceptable eye contact tends to vary considerably with the individual’s culture. For example, direct eye contact is generally considered a sign of respect and interest among middle-class people of European descent. However, members of other cultural groups may avoid eye contact, especially when talking about serious or difficult subjects. The key point is to learn about the cultural preferences and interactional styles of your patient before drawing conclusions about their emotional states, motivation, or behavior.
2. Vocal Qualities

The voice is an instrument that conveys much of the feeling you have toward another person or situation. Changes in voice volume, rate of speech, and pitch convey a substantial amount of information.

3. Body Language

Body language conveys a tremendous amount of information, but it also varies considerably across different cultures. Does he have an open or closed posture? Is she inclining toward or away from you? Your patient’s body language may convey how receptive he feels about sharing his concerns with you, his level of interest in incorporating your suggestions, and other important pieces of information.

Observation Guidelines

1. Look at the way your patients hold their body. What does their body language tell you about their illness? About their attitudes?

2. Look at facial expressions. Is the individual’s expression dull or animated? Is he or she frowning, wrinkling his face, etc.? These expressions may provide clues about the individual’s emotional state.

3. Observe your patient’s level of activity. Is it brisk or slow? Does she appear to be alert or drowsy? This may provide you with important clinical information.

4. Look at your patient’s physical gestures. Observe such things as his hand and body movements. Patterns of movement can sometimes indicate how a person is feeling or thinking. For example, if the person is confused or puzzled about what you are saying, he may rub his neck or furl his eyebrows. It is important to take note of these nonverbal behaviors and, possibly, to inquire about their meaning.

5. Look at his or her appearance. Is she well attired, or are her clothes in need of repair? Do her socks match? Is her shirt buttoned properly? Again, this can provide important clinical information.

Listening Skills

Active listening involves both good attention and considerable self-control. It requires the ability to resist internal distractions and the ability to initially suspend judgment (i.e., to hear what the person is saying before coming to a conclusion). Active listening requires the provider to actively participate by paying attention, asking for clarification, and verbal tracking. Done properly, it is an important part of gathering clinical data and building rapport with your patient.

An important part of active listening is verbal tracking. Verbal tracking means staying with, and encouraging, your patient’s topic of conversation using nonverbal and verbal expressions, such as head nods and minimal encouragers such as “can you tell me more?” As in other areas, pay attention to cultural differences in the use of verbal
tracking. For example, “uh-huh” may be a good minimal encourager for many of your patients, but for others it may convey a sense of arrogance.

**Tips on How to Listen Effectively**

- Pay attention!
- Communicate attentiveness using varied facial expressions and changing tone of voice. Use minimal encouragers to communicate interest and comprehension of the individual’s verbal response.
- Paraphrase the content of the patient’s statements in a more concise form. The paraphrase should reflect the person’s main ideas rather than your concepts.

Paraphrasing consists of:
- A sentence stem (it looks like, seems to me) with use of patient’s key ideas.
- The essence of what the patient said in summarized form.
- Checking for accuracy. “Is that correct?”

**Barriers to Effective Listening**

- Thinking about other things
- Interrupting – this may result from the ability to process information more rapidly than patient’s rate of speech
- Assuming you know more about the patient’s situation than he/she does
- Anticipating what patient is going to say
- Environmental distractions
Physician / Medical Student Nonverbal Communication

Just as it is important to be aware of your patients’ nonverbal behavior, it is also essential that physicians be mindful that they are effectively and appropriately communicating with a patient through their nonverbal behaviors. Your own verbal and nonverbal behaviors can dramatically impact the effectiveness of the interview. For example, a natural, relaxed body style that is your own is most likely to be effective, but be ready to adapt your body position depending on the person to whom you are speaking.

The “SOFTEN” mnemonic is a helpful tool to remember important nonverbal behaviors:

<table>
<thead>
<tr>
<th>SOFTEN: Nonverbal Communication Skills</th>
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<tr>
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Be aware of your use of these nonverbal communications, and be alert to opportunities in which these behaviors can be utilized during the clinical encounter in order to make the patient comfortable and foster a positive and productive physician-patient relationship.
Distinguishing Among Cognitions, Emotions, and Behaviors

In order to conduct an accurate clinical interview, it is important to understand the relationship and differences between cognitions, emotions, and behaviors. Cognitions, emotions, and behaviors interact significantly and have a reciprocal cause and effect relationship. Therefore, when interacting with patients it is important to understand the differences among cognitions, emotions, and behaviors. It is also important to be able to distinguish these actions in yourself as well as in your patients. As doctors, we spend much of our time learning or in cognitive activities; however, recognizing how patients feel as well as how they think and might subsequently behave can be essential components to their treatment.

Definitions:

**Cognition**: knowledge acquired, or how one thinks about a particular person, place, thing, or situation.

**Emotion**: how one feels about a particular person, place, thing, or situation.

**Behavior**: how one acts based on their cognitions and emotions.

The basic assumption of the relationship among cognitions, emotions, and behaviors is that one’s behavior is affected by the way he/she interprets events and situations in his/her life. Or, how one thinks largely determines how one feels and behaves. Additionally, our emotions stem mainly from our beliefs, evaluations, interpretations, and reactions to life situations. An individual’s emotional and behavioral responses to a situation are largely determined by how that individual perceives, interprets and assigns meaning to that event. Finally, these relationships are often reciprocal. In other words, particular behaviors performed by an individual (e.g., finger pricks to check blood glucose) may modify his/her subsequent thoughts or feelings related to that behavior (e.g., “This is not as painful as I thought it would be.”).

The following scenario illustrates some of the distinctions between cognitions, emotions, and behaviors:

Dr.: (in closing) I’ve given you information today regarding your diagnosis of emphysema and your treatment. You seem quite upset. How are you feeling?

Pt.: I think I just need to go home and quit smoking. (cognition)

Dr.: I know that this is not what you were expecting to hear, so it’s understandable that you would be scared and upset. Can we talk about it before you leave?

Pt.: It's just that my father died of emphysema, and I'm really afraid to go through what he did. (emotion)

Dr.: That's understandable, I'm sure thinking about your father's experience and his death is enough for you not to want to deal with this right now (behavior). But we caught it in its early stages, you're young and otherwise healthy, so there's no reason not to expect a good outcome. I'll be glad to talk about this at any time or
answer any questions that you have now or when you're ready. I'll also be here to support you while you quit smoking.

Pt.: Okay, thanks. I know I can't quit smoking on my own; I've tried. I do have a couple of questions about my treatment, and I'm still not clear about what to expect in the future.

By recognizing the difference between the client’s cognitive statement and how he really felt, the doctor was able to further engage the patient in conversation, learn of the patient’s fears, and encourage him to begin adhering to treatment.

**Building Rapport**

Positive clinician-patient rapport has the potential to improve patient assessment, adherence, and treatment outcomes. Rapport requires collaboration, reciprocity, parity, and growth. While there is not one correct way to establishing rapport, the following recommendations have been provided:

**Listen**: Do not interrupt the patient. Use nonverbal communication to show that you are paying attention. Do not become defensive if a patient expresses dissatisfaction – acknowledge the problem, apologize, and fix it if you can.

**Become visible**: When you enter a room, focus on the patient; look directly at him/her and introduce yourself.

**Be reliable**: If you say you are going to do something, then do it. Don’t make unrealistic promises. If you can’t keep a promise you have already made, acknowledge it and try to do better in the future.

**Care for each patient as an individual**: Imagine that the patient is your mother, father, sister, brother. How would you want them treated? (presumably well, so do the same).

**Give the patient some control**: Collaborate with the patient, do not try to control him/her.

**Show support**: Smile and touch when appropriate.

Signs of improved rapport include increased flow of conversation, disclosure of sensitive information, relaxed body language, increased eye contact, better listening and responding. Signs of poor rapport include long periods of silence, sudden withdrawal from conversation, lack of eye contact, brief responses, and defensive body language.
**PEARLS: Responding to Patients’ Emotions**

Another way to build strong rapport with a patient is learning to effectively respond to his or her expressions of emotions. You will observe a wide range of emotions expressed by patients, including fear, anxiety, frustration, disappointment, sadness, anger, pride, relief, and joy. Ignoring or inadequately acknowledging such emotions can damage the therapeutic relationship and make the patient feel that you do not care. In contrast, effectively and sincerely addressing your patients’ emotional responses is key to building strong relationships with them. This will foster an environment in which patients feel comfortable sharing a wide range of clinical information.

Some of the core relationship-building skills can be summarized using the “PEARLS” mnemonic:

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<thead>
<tr>
<th>P</th>
<th>Partnership</th>
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<tbody>
<tr>
<td>E</td>
<td>Empathy</td>
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<tr>
<td>A</td>
<td>Apology</td>
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<tr>
<td>R</td>
<td>Respect</td>
</tr>
<tr>
<td>L</td>
<td>Legitimation</td>
</tr>
<tr>
<td>S</td>
<td>Support</td>
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</table>

The following provides a more detailed review of each skill:

**Partnership:**

*What is it?* An explicit statement indicating physician willingness to work collaboratively with the patient to reach particular goals

*What does it accomplish?* Reduces patient fears of isolation; demonstrates physician interest in the patient and commitment to his/her health

*Examples:*

> “There are several options for treating your high blood pressure. Let’s review some of these, and we can decide together what would be the best approach for you.”

**Empathy:**

*What is it?* The ability to understand a patient’s situation, perspective, and/or feelings, AND communicate that understanding to the patient. *It does not require that the physician feel the same way or agree with the patient.*

*What does it accomplish?* Lets the patient know they are understood
Examples:

“I can only imagine how frustrating it must be for you to be here in the hospital and away from your family for so long.”

“The chest pain you experienced must have been very scary.”

“It sounds like you’re feeling overwhelmed with trying to quit smoking with all the other stress going on in your life right now.”

Apology:

What is it? Acknowledgement of one’s possible involvement in a negative or unwanted outcome for a patient. It can include apologies for failures or suffering caused by the physician, his or her practice/hospital, or the profession. Please note that the words “I’m sorry” are often used as an expression of empathy rather than apology. For example, “I’m sorry to hear about your loss.”

What does it accomplish? Potentially diffuses patient’s anger or frustration over negative outcome. Builds trust.

Examples:

“I am sorry you had to wait so long to see the doctor this morning.”

“I apologize that my office did not follow-up with you by telephone with your test results as I had promised.”

Respect:

What is it? Remaining non-judgmental and accepting another person as a unique and valued individual. One does not have to “like” someone to convey respect. It is expressed through verbal and nonverbal behaviors. Nonverbal behaviors include attentive listening, nodding, eye contact, shaking hands, etc.


Examples:

“I admire how hard you have worked to lose the extra weight and keep it off.”

Legitimation

What is it? Communicating acceptance and validation of patient’s feelings. Normalizing patient’s emotional response. It does not mean that you agree with patient’s response or reasons for an emotion.

What does it accomplish? Validates patient’s experience and emotions. Lets the patient know he has been understood. May diffuse patient’s strong emotions (e.g., anger).
Examples:

“I can understand how this situation would make you angry.”

“Your reaction is very normal. Most patients are very anxious when waiting on test results.”

Support

What is it? Explicit statement that you are available to the patient and want to help.


Examples:

“Let me know what I can do to help.”

“I know these medications are expensive. Let me see if I can find out more about some medication assistance programs for you.”

NOTE: All of these relationship-building skills and the statements used to demonstrate them are only effective when such statements are honest and sincere. Insincere statements of empathy, respect, support, etc. are more destructive than helpful!

Other Considerations for the Clinical Interview

Confidentiality and Disclosure

Confidentiality is a cornerstone of good medical practice. Patients need to know that they can trust their physician to not divulge information about them inappropriately. Without this trust, they may not reveal everything that the physician needs to know in order to help them. However, there are a few important exceptions in which physicians are required to report information that they learn from their patients. These exceptions include topics such as suspected child abuse, elder abuse, or the spread of communicable diseases. The rules and regulations related to this type of requirement vary from state to state.

“Disclosure” refers to the physician’s obligation to disclose the truth to his or her patients. For example, physicians should always tell their patients the meaning of their test results, even when it is bad news. Physicians should also always disclose to patients when they have made a mistake that impacts their care. Telling a patient that you have made a mistake may be difficult, but it is an important part of practicing medicine in an ethical manner.

Jargon and Vocabulary

Most patients have not taken the same course work as you and do not understand the terminology that we use in the medical profession. Keep this in mind when you are speaking to your patients. You will need to communicate with them using words and concepts that they understand. Something as simple as “hypertension” should be
referred to as “high blood pressure” so that it is clear to the patient. Instead of telling the patient that you are about to “auscultate the bowel sounds” you should tell them that you need to “listen to their abdomen.” Whenever possible, avoid using terminology that is found in your textbooks and lectures. When you do need to use technical language, make sure you check your patient's understanding and explain it to him / her when necessary.

**Validation**

Validation is a method of communicating understanding of the patient's thoughts, feelings, or emotions that result from the medical encounter. Keep in mind that a patient may interpret information shared during an encounter in a different way than you expect them to. Therefore, it is important to elicit patients’ feedback regarding what the medical student or doctor has tried to communicate. Ask an open-ended question after summarizing findings and discussing assessments with the patient, such as “How does that sound to you?” Alternatively ask, “Can you reflect on what I just shared with you and give me your feelings about it?” In most cases the patient will be giving you some nonverbal cues even before she speaks. As a physician, it is important to verify the patient's understanding of information discussed as well as how she is receiving the information emotionally. Listen carefully to what the patient does and says, then reflect it back to her, in order to verify your impressions. For example, “It is clear to me that you understood what I told you about your examination but it seems that you are not happy about it. Am I correct?” In addition to providing important corrective information for the physician, this approach validates the patients’ experience and lets her know she has been understood and appreciated by her physician.

**Exhaustion**

It is often important to capture all of the information within a topic. Exhaustion is accomplished by asking the patient if there are more items, and continuing to ask for more items until the answer is nothing more. As already discussed, when setting the agenda this is accomplished by following up the chief concern with “is there something else that you would like to discuss with the doctor?” Examples of other topics that will regularly be “exhausted” include associated symptoms, aggravating and relieving factors, and medications.

**Interview “Flow”**

While it is important to attend to all of the elements of the interview checklist, it is also very important to pay attention to the “flow” of your interview. The order of questions should be logical, and one question should lead to another. Pay attention to your patients’ responses. If you ask a patient about recent stressors and s/he responds that there was a recent death in the family, then take the opportunity to build rapport (e.g., “I am sorry to hear about your loss. How are you doing?”). You should not immediately jump to the next question on your checklist (e.g., “Do you smoke?”), as this conveys that you are not listening or do not really care and can be interpreted by the patient as insensitive. A good interview should flow easily from topic to topic.
Open-Ended and Closed-Ended Questions

Different types of questions will prompt different responses from your patients. “Open-ended questions” invite patients to tell you in their own words their opinions and ideas. “Closed-ended” or “directive” questions call for specific information from the patient. They are useful for filling in details, gathering specific pieces of information, and to check your own understanding of facts. It is generally a good idea to begin with open-ended questions and then move to more specific directive questions.

Characteristics of Open-Ended Questions

<table>
<thead>
<tr>
<th>Examples</th>
<th>DO/ARE</th>
<th>DO NOT/ARE NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tell me what concern has brought you in to see the doctor today?</td>
<td>ARE general questions most effective at initiation of the interview and each new area of inquiry</td>
<td>ARE NOT answered with Yes or No or any other one word answer</td>
</tr>
<tr>
<td>2. Could you tell me more about the pain?</td>
<td>DO help build rapport</td>
<td>DO NOT substitute for an informed and strategic directive question</td>
</tr>
<tr>
<td>3. I’m interested in what you think might be going on?</td>
<td>DO reveal priority or importance of certain items in the patient’s history</td>
<td>DO NOT reveal complete details of the patient’s history</td>
</tr>
<tr>
<td>4. What can you tell me about the health of your family members?</td>
<td>DO require excellent interviewer listening skills</td>
<td>DO NOT work well with some young children and adolescents</td>
</tr>
<tr>
<td></td>
<td>DO share control between interviewer and interviewee</td>
<td>DO NOT give total control to the interviewee to conduct the interview</td>
</tr>
<tr>
<td></td>
<td>ARE efficient in eliciting much information in a short amount of time</td>
<td>ARE NOT efficient in eliciting all fine details necessary to establish definitive diagnosis</td>
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</table>
Characteristics of Closed-Ended or Directive Questions

<table>
<thead>
<tr>
<th>Examples</th>
<th>DO/ARE</th>
<th>DO NOT/ARE NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you experience any discomfort anywhere else when your stomach hurts?</td>
<td>ARE very specific and narrowly focused questions</td>
<td>DO NOT encourage the patient to talk beyond the specific answer</td>
</tr>
<tr>
<td>2. Do you have any nausea when your stomach hurts? What about vomiting? Or diarrhea?</td>
<td>DO retain control of the interview by the Interviewer</td>
<td>DO NOT share control with the interviewee</td>
</tr>
<tr>
<td>3. Are your parents living?</td>
<td>ARE efficient in filling in the details of importance that may not be known to the interviewee</td>
<td>ARE NOT efficient in revealing the ‘BIG PICTURE’ of the patient’s story</td>
</tr>
<tr>
<td></td>
<td>DO require very skilled question formulation by the interviewer</td>
<td>DO NOT save interviewer time if unaware of the context of the patient’s problem</td>
</tr>
</tbody>
</table>

Summarization

Summarization is when you recount what the patient has told you, highlighting the most important issues. It is an important technique that allows the patient to check the accuracy of your understanding and to fill in any blanks with corrected, amended or new information. It also helps you understand any issues that may have been confusing. Using this technique allows you to collect your thoughts and to reorganize your questions before continuing the interview. Summarization does not mean repeating back word for word what the patient has told you. You should summarize the information in a concise manner with only the important information recounted. There is no need to summarize the entire interview; it can be used periodically during the interview, particularly when transitioning to new topics or areas of discussion.

An example of summarization: “So let me see if I have this straight, you started having this cough about three days ago and it seems to be getting worse. You have tried some over-the-counter cough medicine but it has not helped. You are afraid it may be another episode of pneumonia. Do I have all this information correct? Is there anything you would like to add?”

Transitions

Transition statements are used to inform the patient that you are moving from one subject area to the next. Transition statements are especially helpful when moving from one section of the history to another, for example moving from history of present illness (HPI) to functional history, or from past medical history to social history. For example, after summarization of the HPI one can introduce the functional history as follows: “I
have just gathered information about your headaches. Now I’m going to ask you some different questions that relate to general information, outside of the headaches. How are you doing with your work, are you having any problems there?”

The Importance of Silence: “Don’t Just Do Something, Stand There”

Many individuals are uncomfortable with silence during social encounters. Therefore, it should come as no surprise that clinicians sometimes feel the urge to fill silence during the medical interview with additional questions or reassurances. The rush to provide reassurance (e.g., “Everything will turn out alright”; “You will get through this”) may be particularly pronounced when the physician has delivered potentially upsetting news or when the patient is distressed for some reason. Rather than immediately offering verbal support or encouragement in such situations, a silent pause lasting a few seconds is often one of the best ways to show empathy and can be very therapeutic. It allows the patient to continue to express himself if desired, and it also provides the physician an opportunity to further reflect and better understand the patient’s perspective. In addition to demonstrating empathy, silence can serve other valuable purposes in various clinical circumstances:

- For a patient who is exhibiting strong negative emotion (e.g., anger, anxiety), physician silence allows the individual an opportunity to “vent”, which may result in the patient processing the feelings and feeling better.
- For a patient who is providing minimal (e.g., one-word) responses to a physician’s questions, silence accompanied by nonverbal facilitators mentioned previously (e.g., head nod, eye contact, forward lean) may convey your interest in hearing more and encourage further elaboration by the patient.
- For a patient providing adequate information who then becomes silent, a few seconds of additional silence by the physician may provide the patient an opportunity to collect her thoughts and continue with the flow of information.

While silence can be an appropriate and effective tool for physicians to use in some situations, it is not always the best choice. One must be aware of the individual patient, his or her circumstances, as well as potential cultural backgrounds/differences to determine when silence should be used and when other approaches would be more beneficial for the patient’s comfort as well as the physician’s acquisition of needed clinical information.
Medicine and Culture

What is Culture?

In addition to eliciting information about a patient’s symptoms, it is very important for you to understand the patient’s beliefs and understanding of his own problem. These beliefs will be deeply affected by the patient’s cultural background. Culture can be understood as the web of assumptions, beliefs, habits, traditions, and behaviors that bind people together in a common way of understanding the world and living in it. It is important not to confuse culture with race and ethnicity, although they often overlap considerably. You should not assume that people who look or sound like yourself share the same cultural assumptions about health and illness that you do. In a similar manner, you should never assume that people who look or sound different than you don’t share your cultural assumptions. If in doubt, the best thing is to simply ask.

It is very important to remember that every person is a member of different cultures that overlap with one another in complex ways. These include cultures based on ethnicity, geographic region, age cohort, occupation and profession, educational level, and economic status. Each person is a mixture of these various cultural backgrounds and more, as well as one’s own individual beliefs, preferences, and life experiences. Each person brings this complicated mix of cultural background and individuality to the medical setting. Moreover, everybody experiences “culture” in a different way.

This includes you! Every medical student and physician brings his or her own beliefs and attitudes to the practice of medicine. Moreover, as medical students you are in the process of learning the norms of the medical profession and adopting them as your own. Professional medicine, like other occupations and professions, has a distinctive culture that shapes the way its members think. It is important to recognize that your cultural background, both as an individual and as a medical student, is likely to be different from that of your patients. It is important to recognize these differences in order to give the best care possible to your patients.

In order to practice medicine in a patient-centered manner you must try to understand how your patient’s culture(s) influence his or her behavior and response to illness. Good communication facilitates the physician’s understanding of how the patient’s culture(s) will impact diagnosis and treatment. However, you must also try to understand how your own culture(s) may influence the manner in which you provide your patient’s with care. Self-awareness, communication, and active listening are intertwined in the practice of good medicine.

LEARN

The LEARN mnemonic is a useful tool for structuring an interview in a manner that is sensitive to the potential for cultural differences between physician and patient. This interview approach acknowledges the importance of mutual sharing of information between patient and provider. It also highlights the importance of negotiating a mutually agreeable plan based on this exchange of information.
Listen

Listen with empathy and understanding to the patient’s perception and understanding of the problem. Practice active listening. Encourage patients to tell you their “story.”

Explain

Explain your perception and understanding of the problem.

Acknowledge

Acknowledge and discuss the differences and similarities.

Recommend

Recommend treatment based on your best understanding of the problem.

Negotiate

Negotiate a treatment plan that is acceptable to both yourself and your patient. Although this may not, from your perspective, be the optimal plan, it is important that whatever plan you agree on is both acceptable and meaningful to the patient.

**Medical Interviewing and Cultural Differences**

Physicians regularly interview people from different cultural backgrounds than themselves, whether due to differences in age, ethnicity, geographic region, religious belief, socioeconomic status, etc. These differences impact the ability of physicians and patients to communicate with one another. They can also have an important influence on the patient’s perception and experience of illness. Successfully interviewing patients from diverse cultures requires physicians to understand that communication patterns, family roles, and other factors that may influence the perception and course of illness can vary widely from one person to the next. It is also important to realize that interview techniques that work with one cultural group may not always work with other groups.

In order to successfully conduct a medical interview it is important to identify core areas where cultural differences may exist and to explore the meaning of the illness from the patient’s perspective. This is necessary in order to develop a culturally appropriate diagnosis and treatment plan with patients and their family. Failure to do so may lead to poor health outcomes.
Key areas where cultural differences may exist include the following:

- **Style of nonverbal communication.**

- **Autonomy, authority and family dynamics.**

  Although patient autonomy is a core ethical principle in the practice of medicine, you must also recognize the fact that the way people make decisions is influenced by their family relationships, their cultural backgrounds, and other factors. What is the role of the family in patients’ medical decision making process? What is the role of their community and spiritual leaders in their decisions?

- **Attitudes toward biomedicine and other forms of medical care.**

  Attitudes toward biomedicine can vary widely, and these attitudes can impact a patient’s willingness to communicate with you and to undergo certain treatments. What are the patient’s views of biomedicine? Is he opposed to certain forms of intervention? Does he trust physicians to provide good care? Has he or his family had bad experiences with the medical system?

  Furthermore, many patients use other forms of healing practices to maintain their health, including prayer, meditation, and the use of herbal remedies, supplements, or dietary practices. It is important to elicit information about these practices in order to have a complete understanding of a patient’s approach to her health.

- **Religious and spiritual beliefs.**

  Religious and spiritual beliefs can influence a patient’s views about health care, the meaning of illness, and the appropriateness of medical procedures. For example, members of some religious groups may be opposed to certain medical procedures.

- **Sexuality and gender issues.**

  Sexual practices and gender roles can vary widely between cultural groups. It is important to approach these two topics in a culturally sensitive manner that recognizes the fact that human variation in these areas is normal. For example, you should use the appropriate pronoun when addressing a patient who is transgendered or transsexual.
**ETHNICS**

The ETHNICS mnemonic is a useful tool for eliciting information about a range of attitudes, beliefs, and behaviors that impact a patient’s health and illness.

<table>
<thead>
<tr>
<th>Explanation</th>
<th>Probe Questions to be asked:</th>
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<tbody>
<tr>
<td><strong>Direct Question to be asked:</strong> Why do you think you have this… (Use the patient’s phrase for the symptom/illness/condition?)</td>
<td>What do friends, family, and others say about these symptoms? Do you know anyone else who has had or who has this kind of problem? Have you heard about it before? (If patient cannot offer an explanation, ask what concerns him about his problems).</td>
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<tr>
<th>Treatment</th>
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<tr>
<td><strong>Direct Question to be asked:</strong> What have you tried for this… (Use the patient’s phrase for the symptom/illness/condition?)</td>
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<tr>
<th>Healers</th>
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<tr>
<td><strong>Direct Question to be asked:</strong> Who else have you sought help from for this… (Use the patient’s phrase for the symptom/illness/condition?)</td>
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<tr>
<th>Negotiate</th>
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<tr>
<td><strong>Direct Question to be asked:</strong> How best do you think I can help you?</td>
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<tr>
<th>Intervention</th>
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<tr>
<td><strong>Direct Statement:</strong> This is what I think needs to be done now.</td>
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<tr>
<th>Collaborate</th>
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<tr>
<td><strong>Direct Question to be asked:</strong> How can we work together on this?</td>
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<th>Spirituality</th>
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<tr>
<td><strong>Direct Question to be asked:</strong> How can faith/religion/spirituality help you with this… (Use the patient’s phrase for the symptom/illness/condition?)</td>
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</tbody>
</table>
**Working with an interpreter**

It may be necessary to use an interpreter during the medical interview. In some instances, a formal interpreter or telephone based interpreter service may not be available. In such cases an ad hoc interpreter such as a co-worker or family member may need to be used. Never use a child. Be aware of the higher risk of error when using untrained interpreters. Be aware of the need for an interpreter to be neutral and qualified to transmit confidential and sensitive information, especially if using a family member or friend.

Tips for working with an interpreter:

1. Encourage the interpreter to meet with the patient before the interview to discuss the patient’s concerns. When possible, meet with the interpreter yourself ahead of time in order to:
   - Tell the interpreter where you want him/her to sit.
   - Establish the context and nature of the visit.
   - Ask the interpreter if s/he has any concerns to share with you before the visit.
   - Arrange to debrief the interview process with the interpreter after the interview.

2. Introduce the interpreter formally at the beginning of the interview.

3. Use first person if appropriate in the language and speak directly to the patient.

4. Try to use single questions and short phrasing. Break down long segments and questions to shorter segments.

5. Direct questions to the patient, not the interpreter, unless they are meant for the interpreter.

6. Avoid technical terms, abbreviations, professional jargon, and idioms that may be difficult to translate.

7. Encourage the interpreter to repeat the patient’s own words rather than paraphrasing or omitting information.

8. Watch the patient’s nonverbal communication and observe the interactions between the patient and the interpreter for indications that information is not being properly translated.

Promoting Adherence and Providing Patient Education

As one develops his or her skills in clinical interviewing and communicating with patients, one of the most common and important tasks medical students and physicians are called on to do is to provide education/information to patients about their health and/or illness. A related key task is to evaluate and promote patients’ adherence to treatment recommendations.

What is Adherence?

In 1979, Haynes defined compliance as “the extent to which a person’s behavior (in terms of medications, following diets, or executing lifestyle changes) coincides with medical or health advice.” Since Haynes et al proposed this definition 30 years ago, there has been much discussion about the words we choose to describe how well a patient’s behavior coincides with physician advice. Although still sometimes used, the word “compliance” has fallen out of favor because it connotes passive acceptance of provider recommendations. In contrast, the word “adherence” places a greater emphasis on the patient’s role in accepting the provider’s recommendations. So, while we still use the Haynes’ definition, the preferred terminology is “adherence,” not compliance.

Provider-Patient Communication is Key

Notice that the Haynes’ definition consists of two parts: “a person’s behavior” and “medical or health advice.” If the provider does not clearly communicate medical or health advice, the patient cannot be adherent. Many patients fail to accurately understand or remember the physician’s health advice. Clear communication is key.

Tips for giving clear health advice:

- Avoid medical jargon – use simple explanations.
- Avoid vague prescriptions – make your recommendations very specific.
- Give patients your recommendations in writing to take home.

Inadvertent Non-adherence

Inadvertent non-adherence occurs when the patient is sincerely trying to follow the provider’s advice but fails because of misunderstandings, lack of knowledge, or poor skills. For example, a patient might be told to have a light breakfast before a procedure. The physician may use the words “light breakfast” to mean something small, like a piece...
of toast and coffee for breakfast, instead of a large, high calorie breakfast of eggs, bacon, sausage, potatoes and juice. However, the patient may interpret the word “light” very differently, eating a breakfast of eggs, grits, and milk and no coffee because all of these foods are light in color. Obviously, the patient is trying to adhere to the provider’s instruction to have a “light” breakfast but fails because of a misinterpretation of the physician’s instructions.

Inadvertent non-adherence can also occur because patients do not have the necessary skills to carry out a recommended task. For example, many studies have shown that patients who take insulin injections for their diabetes give their insulin incorrectly. This is true for both children and adults. They believe they are giving their insulin correctly but close observation shows they are not. These patients are inadvertently non-adherent because they believe they are following the physician’s advice but their skill deficits get in the way.

Providers need to be sure patients understand their advice and have the necessary knowledge and skills to follow it.

Tips for reducing inadvertent non-adherence:

- Ask your patient to describe the treatment plan in his or her own words.
- Observe the patient carrying out a treatment task.
- Correct errors or misunderstandings.

How Do You Know if the Patient is Following Your Health Advice?

Patient reports of non-adherence are almost always accurate. If a patient tells you that he is having difficulty following the medical regimen, you should believe him!

However, many patients find it difficult to tell their doctor that they have not been following the doctor’s advice and most will not spontaneously report non-adherence. There can be many reasons for this. They may not want to disappoint the provider or feel guilty about their failures. They may expect a lecture from the provider on all the bad things that may happen to them as a consequence of their poor adherence. They may have stopped the treatment because of cost or side-effects. Or they may simply disagree with the provider’s recommendations and not want to follow it.

Providers encourage or discourage patients’ honest reports of non-adherence by their own attitudes and behaviors – both verbal and nonverbal. Providers who “expect” perfect adherence and who are judgmental when confronted with poor adherence will discourage honest reporting. For example, if you want to encourage patients to be honest, you might begin your interaction with the patient by saying, “I know this treatment regimen is difficult. What parts of it have you found particularly difficult to follow?” This gives the patient permission to discuss problems following the regimen and
opens the door for discussing how these problems might be addressed. If the patient describes difficulties in response to this question, the provider might reinforce the patient for his or her honesty by saying, “I am so glad you told me that you are having difficulty remembering to take your medications every day.” Contrast this approach to one in which the doctor asks the patient nothing about the patient’s medical regimen adherence or actively discourages honest reporting by asking leading questions like, “you are taking all of your medications, right?”

Tips for encouraging patient honesty:

- Expect less than perfect adherence.
- Use nonjudgmental communication.
- Support and encourage patient honesty.

Building a Provider-Patient Partnership

Good medical regimen adherence is really about a partnership between the provider and the patient. Based on his or her medical expertise, the doctor provides the patient with recommendations. However, the patient must carry out those recommendations on a daily basis. When provider-patient partnerships are strong, medical regimen adherence is more likely. In this relationship, the provider is responsible for many things: giving appropriate treatment recommendations; communicating those recommendations to the patient clearly; assuring the patient has the necessary knowledge and skills to carry out those recommendations; and creating an environment where the patient feels comfortable discussing questions, fears, concerns, and frustrations openly and honestly. A partnership also implies that the patient has a role in the determination of his own treatment plan. While the provider may recommend a treatment plan, the plan may or may not be acceptable to the patient. Building consensus about treatment goals is critical to good adherence. Building consensus means discussing treatment goals and the pros and cons of different treatment options, exploring the patient’s fears, attitudes, and beliefs about both treatment goals and the various treatment options, and a willingness to negotiate. Often this is a process that occurs over time. The patient may try an approach but find it unacceptable, requiring additional discussion and negotiation.

Tips for building consensus:

- Discuss treatment goals.
- Discuss pros and cons of all treatment options.
- Discuss patient fears, attitudes, and beliefs.
- Negotiate mutually agreeable treatment goals and plan.
- Revisit, revise, and renegotiate as necessary.
Patient education

Patient education is defined as the process of systematically producing changes in the patient’s knowledge, attitudes and skills necessary to maintain or improve health. Skilled physicians have long recognized that patient education provided during the course of care consistently improves morbidity in all patient groups and mortality in high-risk groups. Physicians who do not provide patient education achieve few objectives in the medical visit. Physicians who employ a systematic process for educating patients achieve better outcomes than physicians who use ad hoc approaches. Successful patient education is based not on what the doctor does, but whether or not the patient’s behavior, knowledge, attitudes and/or skill changes.

Systematic patient education has three steps:

1. Diagnosis

   The first step is to diagnose the educational needs of the patient. First, the physician identifies the behavior s/he wants the patient to perform. Choosing a single behavior is important. Physicians have greater success educating the patient to change one behavior at a time. Physicians can then point to this success in subsequent visits when they encourage the patient to change other behaviors. After the physician has selected the behavior, s/he diagnoses the educational needs of the patient by asking open-ended questions to identify any knowledge, attitudinal and skill barriers the patient faces in performing the behavior. For example, a physician might ask the following questions if s/he wants to encourage a pregnant mother to use a car seat for her new infant.

   Knowledge Barriers – “Could you tell me in your own words why the law requires parents to use car seats for their infants?”

   Attitudinal Barriers – “How do parents like you feel about this law?”

   Skill Barriers – “Tell me what you’ve learned about getting and using a car seat for the baby that’s coming.”

   Physicians who listen carefully to the patient’s answers to diagnostic questions like these will be able to develop a personalized education plan. By focusing on real rather than assumed barriers, physicians may actually spend less time achieving their objectives for the visit.

2. Implementation

   The second step in this process is implementing a personalized education plan. Before the physician begins to implement a personalized education plan, s/he has identified specific new knowledge, attitudes and/or skills s/he wishes to address. Patients learn new knowledge from physician explanations. Patients learn new attitudes when physicians present a new attitude and point out how it will help the patient achieve his/her larger goals. Patients learn new skills by trying to perform the skill after someone has demonstrated it to them.
3. Evaluation

The third component in this process is evaluating the effectiveness of the plan. Patients must be able to recall the desired behavior before they can implement it. However, patients recall only 50% of the information on average that physicians relay during a visit. Skilled physicians routinely ask patients to summarize the plan that the doctor and patient decided on during the visit by using questions like this.

“We’ve discussed a lot of information today. To make sure we communicated well, can you please tell what medication you need to take every day?”

Physicians can then correct any erroneous information the patient presents by saying

“I'm glad we talked about this before you left. I must not have been as clear as I tried to be. I thought we agreed that you would……”

Studies show that this approach not only increased patient recall by 35% but also improved patient satisfaction with the visit.

Substantial evidence demonstrates that physicians who provide patient education using this easy-to-learn approach (diagnosis, implementation and evaluation) achieve better visit outcomes than physicians who do not. Rarely in medicine can something so simple result in something so important.
Breaking Bad News

In his influential book *How to Break Bad News: A Guide for Health Care Professionals*, Robert Buckman outlines a six-step protocol for informing patients of bad news in a compassionate and professional manner. The six steps are:

1. **Getting started**
   - Create an appropriate environment for giving the news. Make sure you allow adequate time for the patient and his or her family to process the news. Select a private setting where you will not be interrupted and where the patient can be sitting down. Turn off your beeper and phone. Sit close enough to the patient so that you can provide physical comfort if appropriate.
   - Determine who else the patient would like to have present.

2. **Determine what the patient already knows, including:**
   - What the patient has already been told.
   - How much the patient understands about what he or she has been told.
   - The patient’s level of technical sophistication.
   - The patient’s emotional state.

3. **Determine how much the patient wants to know**
   - Not all patients want the same level of detail or information. Establish the level of detail the patient wants to know.
   - Some patients prefer to designate someone else to communicate with you on their behalf. You should support these types of preferences.
   - Patients may want to know more during their next visit. It is important to re-evaluate their preferences and desires for information.

4. **Share the news**
   - In addition to the diagnosis, consider discussing treatment options, prognosis, and support or coping. It may not be appropriate to discuss all of these during one session.
   - Give the information to the patient in small chunks. Stop between each chunk to make sure the patient understands what you are telling them. Avoid giving long lectures.

5. **Respond to the patient’s reaction**
   - Be prepared for a wide range of responses, including outbursts of strong emotions.
   - Listen. Be quiet and attentive. Use nonverbal communication. Encourage the patient to describe their feelings.
6. Planning and follow-through

- After the patient and his or her family has had time to react to the news and process it, establish a clear plan of action. What is going to happen next? What will treatment be?
- This may take an additional meeting depending on the severity of the news.
- Make sure to arrange for a follow-up session in order to answer additional questions and concerns that may come up.
- Before allowing patients to leave, assess their safety. Discuss potential support systems with them.

General guidelines

*Take it seriously.* Sharing bad news with people is one of the most important jobs that you will do as a physician. The way in which you deliver the news can have a tremendous impact on people, both positively and negatively. Bad news should always be given face to face. Never delegate the responsibility for delivering it to a third party. Doing so can have a significant negative effect on your patient.

*Plan ahead.* Prioritize your objectives and goals based on medical need and appropriate standards of care.

*Take the time necessary to do it right.* It is very important that bad news be delivered in the best way possible. It may take extra time to do so, and it may require more than one interaction. Make sure you give your patient, and their family, adequate time to process the news.

*Do not assume you know how serious the news is.* What may be a minor concern for one person may be a serious, life-altering problem for another. Medical problems impact people in different ways depending on their life experiences, the support systems they have in place, their future plans, their current lifestyles, and other factors. You may not know how serious a particular piece of bad news may be for someone.

*Pay attention to your own feelings.* You may have personal feelings about the news that you are sharing. Sometimes these feelings can be unexpectedly strong. It is important that you have your own support systems in place to help you deal with the emotions that may come up.

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An expert in breaking bad news is not someone who gets it right every time; she or he is merely someone who gets it wrong less often, and who is less flustered when things do not go smoothly.

- Robert Buckman

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Further Suggestions

- Deliver the news in a clear and concise manner.
- Avoid using medical jargon and euphemisms that may obscure what you are trying to say or trivialize its importance. Don’t try to minimize the impact of the news by making it sound less serious than it is.
- After delivering the news, pause. Give the patient time to react to the news.
- Give the patient as much information as needed, or as much as they request, but do not overload the patient with more information than is necessary.
- Offer appropriate and honest reassurance.
- Avoid giving a precise prognosis. Discuss the news in terms of a range of possibilities.
- Give the patient and his or her family plenty of time to express their feelings. Do not rush them. Legitimate their feelings. Do not contradict their feelings or try to argue with them about the meaning of the news.
References


