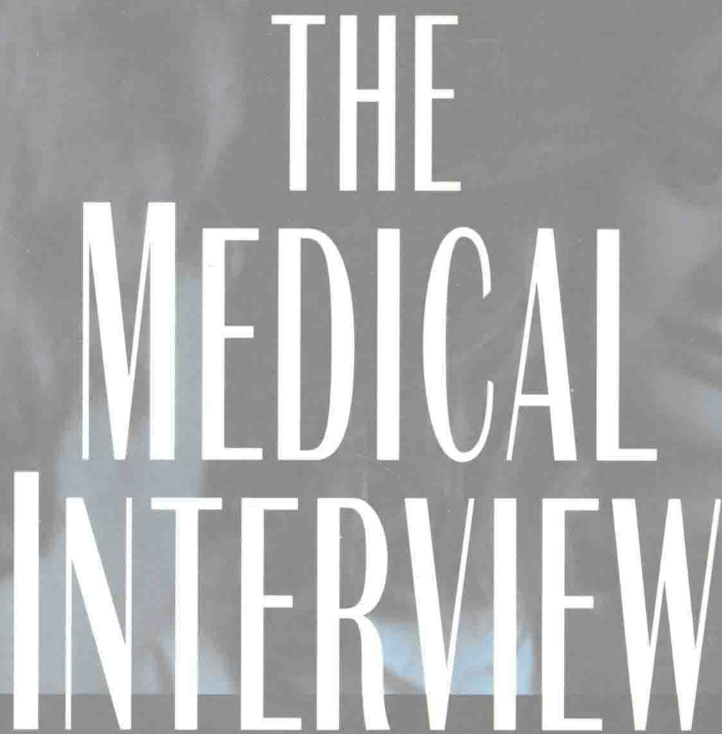

THE MEDICAL INTERVIEW

Mastering Skills for Clinical Practice

third edition

John L. Coulehan
Marian R. Block

The Medical Interview:

Mastering Skills for Clinical Practice Third Edition

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The Medical Interview:

Mastering Skills for Clinical Practice

To Our Families

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Foreword

I hesitated in accepting Jack Coulehan and Marian Block's kind invitation to write a foreword for the third edition of their landmark interviewing text. Did I really want to read it for the third time? Since I am the senior editor of a competing text, would I be cutting off my nose to spite my face? Who wants to write a foreword anyway?

On the other hand, a foreword is a chance to put a small frame on a work, to place it into a broader context that may help or inspire the reader. I really enjoyed my reading of the first two editions of their text—it was instructive even for someone like me who is buried in interview research, writing, and organizing. And although the text I edit is suitable for students in the same niche—those starting their journey as clinicians—this text is specifically designed for them and is without equal as a guide to initiate the process.

With that ambivalence on my shoulders, I read through the book as the finished, typeset chapters arrived in small bundles. I was not prepared for the surprise and pleasure I experienced. This is more than just a revision and updating. Every edition of the book has increasingly reflected the authors' love for their work, the growth of their craft as writers, and the development of their special ability to convey difficult concepts in an almost lyrical, certainly inspiring, way. Every edition has taught me a lot.

As a toiler in the vineyards of helping new doctors achieve greater effectiveness, satisfaction, and fascination in this most astonishing profession, I found this book to be like a cold drink under the hot sun. I am so glad the authors have stuck with this project over these many years, since it offers a serious opportunity to students to begin their work with patients with real insight and good habits.

Why is the interview so important and why is it so necessary to teach students about it from the outset of their professional work? The interview

is the core clinical skill. It determines the quality and quantity of data the health care professional has to work with in identifying and solving the patient's problems. It determines the quality of the relationship between practitioner (or student practitioner) and patient, a relationship that is key to patient cooperation and satisfaction, to practitioner satisfaction, and to helping the patient grow and develop. It determines as well the patient's understanding of what is going on and being done, his or her willingness to take the risk of a true partnership with the practitioner, and the likelihood that the patient will participate effectively in such matters as going for tests, taking medications, and changing lifestyle.

Surprisingly, most practitioners who are active today have never been observed conducting an interview by someone who is an expert in the process and able to give them feedback. Can you imagine taking a plane in which the pilot had never been observed piloting? Until recent years, most students graduated from medical school and residency without serious curricular commitment to teaching these skills and attitudes, and without real formal knowledge of the rather vast base of data concerning what works and what doesn't. Exaggeration? Just consider the reactions of the public to doctors: they don't listen; they don't understand; they made a mistake because they didn't hear all the facts; they don't care about me, only my money. You have heard these complaints at family gatherings or elsewhere for years. Consider the rates of excess testing, surgery, procedures—all almost 40 to 50 percent higher than in other countries. Consider the rates of detection of mental problems in patients: from 50 to 80 percent of such problems are missed! Consider that doctors as a group are dissatisfied and that studies show that the number one factor in physician job dissatisfaction is the poor quality of doctor-patient relationships.

These are some findings about the importance of the interview and the results of bad training in years past. What do we know about the interview? Approximately 8000 articles, chapters, and monographs have been completed about the interview, and there are at least two quarterly periodicals about it. There are organizations concerned with research and education about it in the United States (The American Academy on Physician and Patient) and the United Kingdom (The Medical Interview Teachers Association). The studies have shown that the interview has three functions: gathering information, developing and maintaining a therapeutic doctor-patient relationship, and educating the patient and negotiating a treatment approach. There are 12 structural elements. Each of these has specific skills that, if performed appropriately, improve the outcomes of the interview process that we care about, such as accuracy and completeness of data. These skills can be taught explicitly and can be measured live or from video review.

We also know something about what succeeds and what fails in teaching these matters. First, knowledge of the interview (its functions and structural elements, why open-ended questions are important, and when such

questions should be used), the skills involved (actually practicing each of the elements and types of questions, for example), and the related attitudes ("this is my most important clinical skill; I am going to get it right to begin with and then monitor my effectiveness and continue to grow throughout my professional lifetime") must not only be taught, but must be taught in parallel, in an integrated way. Second, focusing on specific behaviors and practicing with feedback are the best ways to develop good habits, just as in tennis or skiing lessons. Third, attention to the feelings and concerns of the learners as they undergo this major transformation in how they relate to others determines the ultimate outcome. The personal barriers one brings to relationships carry over into the professional arena, and barriers arising from the learning process and from encounters with difficult or traumatic patients can endure and close off critical areas of inquiry or function for the duration of the learner's career.

This book embraces these principles even as it makes the process of learning about the interview entertaining and inspiring. It is like having the opportunity to learn to dance from Balanchine or to play tennis from Arthur Ashe. Placing your future in the sure hands of Coulehan and Block is a wise move that will help to ensure a strong start on your journey.

MACK LIPKIN, JR., MD
NEW YORK

Acknowledgments

The Medical Interview includes numerous examples of physician-patient interactions. Almost all are abstracted from taped interviews, although in every case we have removed personal references that might serve to identify the physician or patient. In some cases we have altered the transcripts (mostly by shortening) in ways that serve to demonstrate specific points more compactly. We are grateful to the patients and physicians who permitted us to tape and publish these conversations.

We wish also to acknowledge our debt to teachers and colleagues. Three outstanding physician-educators deserve special thanks. Eric J. Cassell, MD, taught us how to observe the physician-patient interaction systematically and encouraged us in this work for many years. Alvan Feinstein, MD, taught us that the medical interview is a source of scientific data about the patient and inspired us to find the science in the art of history taking. Kenneth D. Rogers, MD, gave us the wholehearted and sustained support we needed, first, to develop our course in medical interviewing and, later, to write this book.

In the years since the first edition of this book was published, we have continued to learn from our students, our patients, and our colleagues, as well as from the burgeoning literature on the analysis of physician-patient interactions. We also want to thank Marcy Cloherty and Lisa Dougherty, who provided invaluable help in preparing the manuscript and coordinating the endless mail, fax, and telephone interactions of two authors now working in offices 500 miles apart.

Although each of us had primary responsibilities for writing certain chapters, this book is a joint product; in a very special sense it is truly a collaborative effort, and we are both responsible for the entire text.

John L. Coulehan, MD, FACP
Marian R. Block, MD, ABFP

Introduction

THE POOR HISTORIAN

History-taking, the most clinically sophisticated procedure of medicine, is an extraordinary investigative technique: in few other forms of scientific research does the observed object talk.

Alvan Feinstein

Clinical Judgment

They cluster in the hall on rounds, eight of them—students, house officers, and attending physician—creating turbulence and obstructing flow. A medication nurse pushes a cabinet around them on the way down the hall, while the breakfast lorry closes in from the other direction. An intern begins the presentation with "Mr. Blank is a 52-year-old man who presents with abdominal pain . . . the patient is a poor historian. . . ."

The attending physician learns that this sick person "claims" to have a number of symptoms and is apparently taking several medications. The intern hastens to add that Mr. Blank's compliance is poor; he doesn't seem to understand his illness; and he is, after all, a "poor historian." Having thus dispensed with preliminaries, the intern moves on to reporting the patient's physical findings and initial laboratory data. At this point all qualifiers are dropped: the magnesium level does not *seem* to be 2.2, it *is* 2.2. Meanwhile, the attending physician reflects on the term "poor historian," perhaps because of an unconscionable lack of interest in magnesium. The matrix of numbers vibrating among students and house officers takes on a life of its own while the attending physician wonders about this patient's "poorness."

The physician knows what the intern is trying to tell the group with the phrase "poor historian." The young physician does not intend to say that the patient is an impoverished professor of history. Nor does he or she mean that the patient is a history student with poor grades. No, the intern is saying in precise medical shorthand, "I was unable to reconstruct a logical story of the illness in my conversation with this patient. We did not communicate well." Reflecting further, the attending physician finds the term "poor historian" acceptable but wonders if the attribution is correct. Perhaps the intern would be more correct in saying, "The medical history is unclear because *I'm* a poor historian."

This vignette illustrates how data we obtain from speaking with the patient and the therapy we accomplish through the process of physician-patient interaction are not often topics for discussion during medical rounds. Although we consider information about serum magnesium, for which accuracy and precision is assumed, a fit topic for discussion, knowledge of the precise pattern of symptoms or the patient's beliefs about the symptoms appears less scientific and less relevant. Clinical students soon learn to spend less time listening to the patient's story and more time among their peers at the unit station agonizing over the meaning of a magnesium value. Trainees learn to accept responsibility for how well (or how poorly) they perform a bone marrow aspiration, interpret an x-ray, or insert a flexible sigmoidoscope. As physicians, we rarely blame the patient for an inadequate bone marrow aspirate, yet we believe the hospital is full of patients who perpetrate poor histories.

Stories of sickness and suffering—the kind of human stories that moved us to enter a healing profession in the first place—gradually move to the background as we become "socialized" into the technical culture of medicine. Students and physicians become preoccupied with quite different stories, technical tales in which organs and instruments rather than people are the protagonists. Sometimes, in fact, the patient's story is entirely forgotten: nowadays it is not rare in clinical practice for investigations to bring some unexpected results to light, and these lead to more examinations along a side track. After a while the whole staff is interested in, say, the incidental finding of a renal cyst on an abdominal CT scan, and nobody remembers why the patient was admitted. Only on the day the patient is discharged will he or she complain, "But you haven't done anything about my fatigue!"

This illustrates a narrow view of the clinical enterprise, one that permeates medical education; the view is that real medicine is solely concerned with objective data such as numbers, graphs, and images. This is associated with the belief that so-called subjective data (for example, the story a patient tells us) are necessarily lacking in quantification and so also must be lacking in clinical value. In other words, what patients feel, the suffering they experience, and the disability that haunts them, all of which they describe only indirectly through the medium of words, are secondary in importance to

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those physiologic quantities that can be observed directly by physicians. Physicians, according to this premise, must address what causes all this suffering and pain: altered physiology, abnormal biochemical findings, or disease. The real work of medicine requires us to reduce persons and their illnesses to organs and diseases. In this view, if you correct bad numbers, suffering will go away. You don't have to pay much attention to who the patients are or to the fine details of their stories.

In fact, the patient and his or her story often get in the way of "real" medicine. The patient "comes to function as a kind of translucent screen on which the disease is projected . . . (but) the screen has opacities of its own which obscure the accurate perception of the underlying disease."[1] The poor historian, the patient with whom we have difficulty communicating, has many such "opacities." It is difficult to see through the person to observe the disease.

But should the patient be merely an obstructive screen that we try to work around or to see through? A broader view of medicine holds that the patient's stories—stories of sickness—lie at the center of medical practice. The great clinician and medical educator William Osler wrote, "It is a safe rule to have no teaching without a patient for a text, and the best teaching is that taught by the patient himself." In fact, experienced clinicians are aware that, in general, about 70 percent of diagnoses are made on the basis of patient interviews and over 90 percent are made on the basis of history and physical examination. Primary physicians spend the largest part of their clinical time talking with patients; they generate most of their diagnostic hypotheses on the basis of the history, and most of the significant bits of information they use arise from this dialogue.

Despite widespread lip-service to this broader view of medicine, until the last 20 years medical schools generally did not include interviewing skills in their curricula. Medical educators did not consider history taking and talking with patients appropriate topics for serious study. These educators gave students "little black books" that included lists of questions about symptoms and past diagnoses. If the patient did not answer these questions clearly, concisely, and in a medically acceptable fashion, the patient was labeled a "poor historian." Clinicians told their students, "Talking with patients is important, but you'll pick up how to do it as you go along. The doctor-patient relationship is also important—crucial, in fact—but you'll pick that up as you go along, too. You just need experience."

For a number of reasons, this attitude toward communication skills in medicine has changed in recent years. First, we have discovered that highly specialized, machine-intensive medicine is not necessarily the "best" medicine. Patients often find themselves doing better by the numbers but feeling worse. They may undergo the most advanced tests and see the "best" specialists, but find themselves feeling just as sick, and often angry and confused as well. At the same time, academic physicians have begun to understand

that pain, suffering, and dysfunction must be conceptualized in broad human terms as well as in biochemical terms if we are to be effective healers. Clinical practice must be based on a biopsychosocial or holistic model rather than on a purely biologic model.

Second, in the last generation more and more investigators have studied the process of interviewing and analyzed its individual components. This work, along with studies in fields as wide-ranging as medical anthropology and clinical decision making, has shown that the "art of medicine" can be articulated and taught systematically. It is not simply a matter of intuition and experience.

Third, patient-oriented studies have shown that good patient-physician communication leads to good outcomes, improved patient satisfaction, and better adherence to treatment. Alternatively, poor patient-physician communication leads to poor outcomes, doctor-shopping, and excessive malpractice suits. In fact, when an adverse event occurs, physician insensitivity and poor communication are the major factors in a patient's decision to sue.[2,3] Finally, the pressing need to limit the costs of medical care has led to a renewed emphasis on generalist care, in which physicians use resources more rationally by knowing more about their patients. This certainly has been a key feature in the movement toward HMOs and other managed-care arrangements.

This book is based on the premise that interviewing and patient-physician communication are essential to good medical practice. Talking with patients is not a skill reserved for psychiatrists and primary care doctors. It is essential for radiologists as well as internists, ophthalmologists as well as pediatricians. Medical interviewing is a basic clinical skill. It is not a matter of common sense, nor does it come necessarily with experience. It is a skill that can be broken down into its component parts, and it can be learned. That is the subject of this book.

The Medical Interview is addressed primarily to students of medicine and other health professions who are about to begin their professional interaction with patients. It is designed to be a guide for those who are just learning to take a medical history and interact with patients, as well as a resource for those who are further along in their education, including postgraduate trainees. Our particular emphasis is on the microskills of the initial patient interview. Although we deal extensively with basic history taking, the same skills serve as building blocks for all types of patient-physician interactions. They lie at the core of the art and science of medicine.

The book is divided into two major sections. *Basic Skills: Understanding the Patient's Story* presents fundamentals of clinical interviewing (Chaps. 1 and 2) and various components of the medical history (Chaps. 3 through 7). *Basic Skills in Practice: Applying the Patient's Story* deals with more complex or difficult interviewing situations, along with additional topics relevant to the clinical interview. Chapters 8 and 9 consider aspects of the

interview as adapted to pediatric, geriatric, primary-care, and managed-care encounters. We review various barriers to communication and sensitive or difficult situations in Chapters 10 and 11. The final chapters deal with screening and case finding through the use of questionnaires (Chap. 12), clinical judgment as manifested in patient-physician conversations (Chap. 13), understanding the patient's beliefs and values (Chap. 14), and patient education and negotiation (Chap. 15).

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Contents

Introduction
The Poor Historian xvii

PART ONE
BASIC SKILLS: UNDERSTANDING THE PATIENT'S STORY 1

CHAPTER 1
I Attach the Same Meaning
Interviewing as a Clinical Skill 3

OBJECTIVITY, 4
INTERPRETATION VERSUS OBSERVATION, 5
PRECISION, 8
SENSITIVITY AND SPECIFICITY, 10
REPRODUCIBILITY, 11
SCIENCE AND ART AT WORK, 13
SAGA OF THE FIFTH WHEEL, 15
SUMMARY: SCIENCE AND ART IN INTERVIEWING, 18

CHAPTER 2
With Simple, Kindly Words
Respect, Genuineness, Empathy 20

RESPECT, 23
GENUINENESS, 25
EMPATHY, 27
LEVELS OF RESPONDING, 28
USING WORDS TO IDENTIFY SYMPTOMS AND FEELINGS, 33

NONVERBAL COMMUNICATION, 34
CHALLENGES TO UNDERSTANDING EXACTLY, 39
SUMMARY: CORE THERAPEUTIC SKILLS, 40

CHAPTER 3
Why Should You Come to Consult Me?
The Chief Complaint and Present Illness 42

THE SETTING, 43
GETTING STARTED, 43
THE CHIEF COMPLAINT, 45
THE PRESENT ILLNESS, 49
A FEW EXAMPLES, 57
CHALLENGES TO ELICITING THE CHIEF COMPLAINT AND PRESENT ILLNESS, 59
SUMMARY: CHIEF COMPLAINT AND HISTORY OF THE PRESENT ILLNESS, 64

CHAPTER 4
Transforming Experience into Memory
Other Active Problems, Past Medical History, and Family History..... 66

OTHER ACTIVE PROBLEMS, 67
THE PAST MEDICAL HISTORY, 69
FAMILY HISTORY, 73
SUMMARY: OAP, PAST MEDICAL HISTORY, FAMILY HISTORY, 80

CHAPTER 5
Gaining Richness and Reality
The Patient Profile 81

WHAT GOES INTO THE PATIENT PROFILE?, 82
DEMOGRAPHICS AND OCCUPATION, 84
CULTURAL AND HEALTH BELIEFS, 84
LIFESTYLE, 88
RELATIONSHIPS, 91
SEXUAL HISTORY, 93
THE PATIENT PROFILE AT WORK, 97
SUMMARY: THE PATIENT PROFILE, 101

CHAPTER 6
No Air of Finished Knowledge
Review of Systems, Physical Examination, and Closure 102

THE REVIEW OF SYSTEMS, 102
TRANSITION TO THE PHYSICAL EXAMINATION, 109
CONVERSATION DURING THE PHYSICAL EXAMINATION, 111
ENDING THE INTERVIEW, 115
SUMMARY: THE ROS, PHYSICAL EXAMINATION, AND CLOSURE, 118

CHAPTER 7
I Shall Enumerate Them to You
Getting It All Down and Communicating to Others 120
WHAT GOES INTO THE WRITTEN HISTORY, 121
FUNCTIONS OF THE MEDICAL RECORD, 123
FORMAT OF THE MEDICAL RECORD, 124
PROBLEM-ORIENTED RECORDS, 130
SUMMARY: THE CLINICAL NARRATIVE, 132

PART TWO
BASIC SKILLS IN PRACTICE: APPLYING THE PATIENT'S STORY 135

CHAPTER 8
A Different Silhouette
Pediatric and Geriatric Interviewing 137
THE PEDIATRIC PATIENT, 138
THE ELDERLY PATIENT, 147
SUMMARY: TECHNIQUES FOR YOUNG AND OLD, 156

CHAPTER 9
The Real Satisfaction
Interacting with the Patient in Primary Care 158
SOLVING COMMUNICATION PROBLEMS IN PRIMARY CARE, 159
SPECIFIC ISSUES IN MANAGED-CARE SETTINGS, 171
PREVENTIVE HEALTH CARE, 175
CONFIDENTIALITY AND TRUTHFULNESS, 176
MALPRACTICE LIABILITY, 179
SUMMARY: COMMUNICATION IN PRIMARY CARE PRACTICE, 180

CHAPTER 10
Seal Up the Mouth of Outrage
Interactive Problems in Interviewing 183
INTERACTIVE STYLES, 184
SOMATIZATION, 193
DIFFICULT FEELINGS IN THE MEDICAL INTERVIEW, 198
SUMMARY: DIAGNOSING AND TREATING THE "SICK" INTERVIEW, 209

CHAPTER 11
Something New and Dreadful
Telling Bad News 212
BARRIERS TO COMMUNICATING BAD NEWS, 213
EMPATHY AND INTERACTION IN TELLING BAD NEWS, 218
ADVANCE DIRECTIVES, 222
SUMMARY: COMMUNICATING BAD NEWS, 225

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