Contemporary Themes

Listening and talking to patients

II: The clinical interview

CHARLES FLETCHER

"In my private practice I listen to my patients; in the hospital I talk to them," a consultant physician told a *Sunday Times* reporter recently. This contrast in behaviour matches the difference that Byrne and Long[1] drew between "patient-centred" and "doctor-centred" interviewing. Another way of expressing this contrast is between the traditional skills of "history taking" and the wider skills of "interviewing." History taking has conventionally been taught as a technique of questioning the patient by which the doctor attempts to extract from him the information needed to diagnose physical disease. Interviewing includes this but extends to discovering, by listening and encouraging the patient to talk, what sort of person he is and how his illness affects him. In this way the doctor is more likely to discover what sort of person he has to help and how he is reacting to his illness. Interviewing demands more subtle strategies and wider skills than history taking.

The strategy and tactics of interviewing, the sort of mistakes that are commonly made, and how they may be avoided have been ably set out by Maguire and Rutter[2] and are summarised in the recent Nuffield Provincial Hospitals Trust booklet.[3] I first heard Maguire's interview model when I was near to the end of my clinical career and much regretted that I had not been given it to work on as a student. I shall attempt to summarise it and to indicate the skills required for its execution, hoping to encourage readers to consult the original.

Skills and strategies

STARTING THE INTERVIEW

This is where the tone of the interview is set. Patients are usually apprehensive; they must be convinced of our personal interest and concern with them from the outset. We should stand up to greet each patient: physical contact—at least a welcoming handshake—can both reassure and give friendly encouragement. Chairs and tables should be arranged to encourage easy discourse. A brief explanation of what is to be done—including note taking as an aid to memory—can help new patients. The first question must always be open: "What is the problem?"; "What have you come about?"; "Well, tell me about it." And in hospital when the patient comes with a doctor's letter: "Your doctor has written to me, but I want you to tell me about it all yourself." Many patients first offer a symptom that masks what they really want to discuss, so they must always be encouraged to say if anything else is bothering them.

It is hard for doctors to realise that patients may be so over-awed by them that they conceal their main worries. A woman with puerperal depression said, "When I got there and sat down I didn't dare tell him . . . in fact I told him a whole string of lies."[4] If doctors don't recognise and overcome this trepidation in their patients they may miss the diagnosis. What is needed is "empathy": this means being aware of how the patient is feeling, and showing this understanding by facial expression and verbally.

FACILITATION

Facilitation may be verbal—"Go on; tell me more about that" —or non-verbal—just an encouraging noise, or nodding and waiting. The proper use of silence is important and needs to be learnt. So many interviewers—and I have learnt this myself by listening to audiorecordings of my own interviews—lose important clues by jumping in too soon with the next question. Interrupting to bring the patient back to the point may be needed to check irrelevance, but must be carefully done to avoid the risk of shutting the patient up.

CLARIFICATION

Clarification requires direct questions about the onset of symptoms, their development, precipitating and relieving factors, and so on. These questions must not be asked so as to suggest the answer—for example, "You don't get pain in your shoulder, do you?" They must be put in simple, lay terms. A rapid string of questions may confuse the patient, especially if they are phrased in technical terms. An intelligent patient wrote, "If I do not answer immediately a fresh question is thrown at me . . . it seems wrong to ask him to slow down. . . . Some doctors' questions are simply unintelligible."[5] Throughout the inquiry careful attention must be paid to clues to un-expressed emotion which the patient may give.

TOLERANCE

Tolerance of emotionally disturbing things that a patient may say is needed. If the doctor is to find out about the emotional determinants or consequences of a patient's illness he must not appear censorious or shocked by anything the patient says he has done or thinks or feels. Most doctors have inhibitions or prejudices in certain areas. These must never interfere with

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dispassionate interviewing.[6] A doctor has no warrant for passing judgment on what a patient tells him however shocked he may feel.

AVOIDING JARGON

Patient and doctor may have quite different ideas of the meaning of even simple medical words.[7 8] If there is any doubt, clarification must be sought or an explanation given of any technical words that are used.

SUMMARISING

It is helpful for both doctor and patient if at the end of the interview the doctor summarises what he has learnt and asks the patient if he has got it right or if there is anything more to be said.

NOTE TAKING

Though essential, note taking must not be allowed to spoil the interview. A doctor who never looks up from his notes cannot interview well. Writing can be done in occasional pauses, "Just a moment, I want to make a note of that," or by making a summary after the interview.

Too much emphasis on "real medicine"

Most doctors, and senior medical students, may feel that this brief summary of the main components of a good interview is only an inadequate account of their normal practice. Yet it has been shown that at the end of their clinical years the interviewing skills of many, if not most, students are seriously inadequate.[9 10] Studies of interns in the United States,[11] of registrars entering general practice, and of general practitioners themselves[1 12] suggest that there is little improvement with clinical experience. Why should doctors' interviews so often fail to live up to this fairly simple ideal?

One important reason lies in doctors' attitudes towards the interview. Many of them feel (and some overtly admit) that their interest lies solely in patients' pathophysiology and that they do not wish to become involved in their personal problems. I was told of one registrar who had actually asked his chief how to stop his patients telling him their worries, which just embarrassed him. Teaching in medical schools tends to concentrate on the diagnosis and treatment of physical illness, which I recently heard referred to as "real medicine" on a teaching round. The triumphs of modern therapeutics, both medical and surgical, reinforce this. With so much detail to be learnt about the technical basis of effective practice it is easy for doctors to see their patients mainly as deranged biological machines rather than as people beset by worrying problems. This attitude inevitably inhibits full communication.

The medical interview differs from other interviews in that doctors have to maintain a discrete and proper emotional distance from their patients. If they did not, it would be difficult to discuss the intimate matters that are commonplace in the consulting room but unacceptable in social conversation. We have to ensure that we combine this necessary emotional distance with expressions of courtesy and concern. Those who do not do this appear emotionally remote, so that their patients are discouraged from confiding in them.

Inadequate teaching is probably the main reason why many doctors never become good at interviewing. Medical students are usually taught about "history taking" at the beginning of their clinical years in short introductory courses consisting of a few lectures or demonstrations together with handouts. Their subsequent conduct of interviews is seldom monitored. This may be why they often become less skilled at interviewing in the course of the clinical years.[9 10] Before students have learnt enough to make a provisional diagnosis and to check it with a series of routine questions they tend to listen with interest to what patients have to tell them, but by their final year they have acquired an "inquisitorial" technique that tends to inhibit listening. One final-year student said to me, "The natural instinct at the beginning of the course to treat patients as human beings is gradually destroyed by being taught to treat them as examples of diseases."

Videotapes and audiotapes help

Few students have any opportunity to see themselves talking with patients so that they remain unaware of mannerisms, verbal or non-verbal, which may discourage their patients from talking easily. Videotape teaching provides essential feedback. Teachers who have used the method are invariably convinced of its value, and controlled trials have shown that when students are able to see the mistakes they are making by watching their own interviews guided by a tutor they develop better skills than those taught by conventional methods.[13 14] Audiotape recordings are not quite so good but are also effective.[13] Experienced GPs have also shown improvement from this self-observation,[12] and consultants could presumably also benefit. I certainly wish I had been able to see myself talking to my patients. Any doctor can make his own audiotape recordings of a few consultations and by listening to them subsequently see what mistakes he may be making and be able to correct them.

Teachers who have used videotape report that a few students fail to improve. They seem to find it difficult to relate to patients and to put them at their ease. It might be valuable to identify such students early: they may need special training or perhaps should be advised to go into a non-clinical branch of practice.

Time is short

Shortage of time is the commonest reason advanced for poor interviewing, especially in general practice. The important facts about many patients with common disorders may be learnt in a few minutes,[15] and the minority who may need a more lengthy interview can also be detected quickly. GPs tell me that half an hour allocated later on to such patients may save the five minutes every fortnight for a year or more that they would otherwise have needed. Consultants usually have more time, but they still need to make efficient use of it. In surgical clinics, which are often rushed, the interview can be brief, for the diagnosis often depends chiefly on the examination; but time must always be found to say what must be done in a way that will allay anxiety and give reassurance, matters which I shall deal with in the next two articles.

This is the second in a series of articles on listening and talking to patients.

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Reading for Pleasure

Book of Kings

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I want to write not about books but about pictures. I am not shirking my responsibilities as the writer of a book column, for the pictures in question were once part of a great mediaeval volume and this year a facsimile of this work has been published in America. The Iranian *Book of Kings* ("Shahnameh") was written around the tenth century by Firdausi. I speak not one word of Persian and had never heard of Firdausi or his *Book of Kings* until a few months ago, but it is worth pausing a moment to talk about his poem before describing the great paintings it inspired. The *Book of Kings* is like a hybrid of the *Iliad* and the two Books of Kings in the *Old Testament*. Like the ancient Greeks and the Jews, the Iranians had assembled a partly mythical, partly historical account of the kings of antiquity, ranging from the implausible Zahhak (who is punished for his crimes by sprouting two snakes from his shoulders) to quite reasonable kings, who play diplomatic polo matches with Roman caesars or seek the hand in marriage of the daughter of the Khan of China. Firdausi spent 35 years writing the 30 000 couplets of the poem and dedicated it eulogistically to a certain Sultan Mahmoud, who gave him so little thanks that he took his miserable payment from the court and gave it to a bath attendant and a sherbet seller. He died disillusioned, and one is reminded of Samuel Johnson after a similarly unpatronised labour of love 800 years later:

> I have protracted my work till most of those whom I wished to please have sunk into the grave, and success and miscarriage are empty sounds: I therefore dismiss it with frigid tranquillity, having little to fear or hope from censure or from praise.

Nevertheless, as with Johnson, Firdausi's posthumous success was not diminished by his patron's coldness. His epic became to Iranian painters like a book of the Bible to the makers of stained glass windows in Europe. Schools of miniaturists and calligraphers created illustrated versions for their patrons. The greatest of these is said to be the volume begun in Tabriz in 1522 and completed perhaps 15 years later when the 258 masterpieces by 15 artists were presented to Shah Tahmasp. Although in his youth he had been one of the greatest patrons, Tahmasp seems to have become like Firdausi's patron Mahmoud, for he lost interest in his artists and gave the *Book of Kings* in its splendid new edition to the Turkish sultan. It is not recorded how the 15 artists felt, though many are known to have emigrated, nor was there an outbreak of lavish ostentation among bath attendants and sherbet sellers.

A new flurry of interest

The work remained locked away in Turkey until late in the last century, when it was bought by a Rothschild, who locked it away for another half century until the American collector Arthur A Houghton jun bought it in 1959 and presented 78 of the illustrations to the Metropolitan Museum in New York. The ravages of inflation may now be affecting the Houghton family, for individual folios are being sold. This has coincided with a flurry of commercial and academic interest which has brought it to the attention of people like myself, who knew nothing of the book or of its time or place of origin. Seventeen of the folios were exhibited during July and August last year in Agnew's gallery in Bond Street, and another 38 formed part of the exhibition "Wonders of the Age" shown in the King's Library of the British Museum from August to October, and which is travelling to the United States. The entire *Book of Kings* was published in reproduction by the Harvard University Press this year.

The first point I want to make about these miniatures is how great is the illusion of movement in them. Exuberant crimsons and white and lapis lazuli spill out from the gold geometrical borders, as though the characters and objects contain too much life to be contained inside. Horsemen ride out of these borders; rocks and trees burst through; and banners wave across them. Pink and grey rocks, each mysteriously bearing the face of a dog or monkey or human being, pour forth black waterfalls which flow as rivers across plains of mauve or green. Valleys teem with vegetation in minute and perfect detail. The palaces are adorned

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