

The Medical Interview

Mastering Skills for
Clinical Practice

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FIFTH EDITION



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The Medical Interview includes numerous examples of clinician-patient interactions. Most are abstracted from taped interviews, although in every case we have removed personal references that might serve to identify the clinician or patient. In some cases we have altered the transcripts in ways that serve to demonstrate specific points more compactly. We are grateful to the patients and clinicians 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 clinician-patient interaction systematically and encouraged us in this work for many years. The late 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. The late Kenneth D. Rogers, MD, gave us the whole-hearted 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 clinician-patient interactions. 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
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FOREWORD

Forewords are best brief and useful to the browsing or assigned reader. Like the classic Greek funeral oration a proper foreword is expected to bring praise upon the fallen (read: editors) in 20-plus prescribed ways.

Inherently and inevitably, daily work in medicine itself shares this conflict between brevity and fulfillment of task. On the one hand, you are being mightily socialized as learning-doctors to be brief, get to the heart of the matter, and present complex issues in few, succinct sentences. It is argued you must do all this in the names of busy-ness, business, being professional, and remaining objective.

On the other hand, gurus such as Coulehan and Block, sadly cursed with classic virtues, exhort you upon meeting each and every patient to listen, hear, understand, know with precision and completeness the disease and the illness, feel deeply and personally, show empathy but not sympathy, find respect for every patient from presidents to professors to corporate or other giants to the morally evil, spiritually bereft, foul and smelly, unmotivated, hostile, threatening patient your mother trained you to cross the street to avoid. Dear authors, come on, get real. Do you demand saintliness?

Such virtues are received so early in medical school they may feel handed down and therefore instinctively to be distrusted, especially when presented as commandments or charismatic invitations (medicine is an art, you therefore should become an artist, the easy way being to do exactly as I do, or even safer, become me; the narcissistic imperative, injected transformation). In fact, the approaches taught here have been blessed by robust science as *the critical elements of the best medicine*.

The best medicine is the sort you aspire to provide your patients and that you want for your loved ones. You will shortly be told to also meet institutional standards—to be satisfying to patients (who will hence come back and pay), efficient, and cost-effective, as we creep like Zeno's paradoxical tortoise racing Achilles ever more closely to rationing and capitation, with the result that institutional survival and the doctor's income rely on becoming faster or cheaper. You will also be advised that you must reduce risk (risk management departments are now almost universal in U.S. hospitals where "risk" refers to the hospital's, not the patient's, risk)

and perform care of the highest quality, as defined by bureaucrats, department chairs, textbook writers (for example, Coulehan and Block and, mea culpa, myself as well), and medico-industrial complexes, such as big Pharma, big Imaging, and big Alternatives.

The behaviors, attitudes, knowledge, and principles Coulehan and Block teach in this book have, mostly, been scientifically demonstrated to result in higher quality, more efficient, more satisfying to you and your patients, and cheaper medical care than do the current norms of practice in communities and major medical schools and centers.

If you don't believe me, refer to the humanely sparse resources and Internet links herein or go to www.doc.com for access to the rich literature supporting my bald-faced assertions.

There will soon come a day when you will have mastered the commonly seen conditions in your practice to the level of your personal standards. Then the true joy and personal and intellectual satisfaction of your clinical work will come *most of all* from your deep encounters with patients as people. (It seems that some practitioners cannot find or have not been shown how to get on the road to such satisfaction and joy. As a result some skip the journey to their and their patients' peril.) Strong data show that the doctors most satisfied in their work, and thus least likely to burn out, exhibit high satisfaction with their psychosocial skills, a balanced approach to the biotechnical and psychosocial aspects of their cases, and personal life balance as well.

I was not initially inclined or skilled in listening (I was impatient), hearing (my mind was full of fascinating, new hypotheses I needed to test), feeling (no time, too painful), expressing emotions or talking about them (oh, please), and on down the list. What I did have were strong observational skills, the drive to be the best physician I could be, and an openness to learning and change. As an intern, I needed to master the big machine of the university hospital so I could spit out diagnoses and handle sick people. Even by that October, though, I was noticing we weren't helping even about a third of our patients. We often knew within 10 or 20 minutes of meeting the patient that the tests would be negative, and we did not know how to help the patients or ourselves in the terrible life situations we encountered: people dying with their eyes glued to ours, killing themselves through addiction or self-neglect, refusing rational chances to improve because of superstitious beliefs, our errors that killed or damaged, the persistence of our colleagues to ply their procedural wares that hurt or wounded many needlessly. You will no doubt write your own, personally salient list.

I set out to find who did know how to help these patients and in these

situations. There was no Coulehan and Block then, and no meaningful, let alone effective, curriculum. So I made it a personal mission as a physician to discover empirically valid ways to be most helpful to patients and practitioners during the medical encounter, and also to find ways of teaching that allowed my learners to grasp the big things—to listen, hear, respect, show empathy, and acquire the Rogerian ways, so clearly noted in Chapter 2. Like a major league batter, I still know that I need regular, disciplined practice, such as listening to tapes of my interviews, monitoring patient's reactions, going to workshops to keep my edge and handle what my patients pitch to me.

Your good luck is that Coulehan and Block have distilled the current state of the art into highly readable, manageable, and practical chunks of interesting information. But like the new vintage wine drinker, don't believe that after one sip the wine will divulge to you its deepest pleasures. You need to open this book, sniff the outline and concepts, then drink slowly, returning again and again as it ages and your ability to understand deepens with experience and reflection.

Now, that was the peroration. This is the exhortation.

Take this book seriously to heart and mind, master what it teaches, and return to this or subsequent editions, or more advanced works as you deepen and grow. Buy many copies of this book to ennoble your friends and relatives (and also enrich the authors and publishers). The book presents foundational skills for you as a physician. As a mason of careers, I urge you to commit to building a rock-solid foundation and, later, to annually assessing and improving some part of it through self-review by videotape, through peer review, or by taking courses designed to help practitioners continue to grow as communicators and healers.

Mack Lipkin, MD

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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 nurse pushes a medication cabinet around them on the way down the hall, while the breakfast lorry closes in from the other direction. A medical student begins the presentation with “Mr. Blank is a 52-year-old man who presents with abdominal pain ... the patient is a poor historian.”

Generations of physicians hearing a statement like this have had no problem understanding the speaker’s intended meaning. In the culture of medicine, the term “poor historian” refers neither to the patient’s occupation nor to his or her economic status. Rather, the term is usually used to blame the patient for an unsatisfactory outcome to a clinical interview. Despite the fact that the clinician performs the skilled professional work of the interview, we tend to assign an active role solely to the patient (“historian”), with the clinician presumably relegated to the status of passive observer.

The “poor historian” highlights a strange paradox in medicine. We teach entering students that the clinical history is the most important source of diagnostic information; in fact, perhaps 70% to 80% of all relevant data are derived from the medical interview. We also teach that the clinician-patient interaction is an important therapeutic tool. We reaffirm these beliefs in lectures, seminars, and clinical “pearls” throughout undergraduate and graduate medical education. Similarly, we teach a whole

range of patient-centered practices and values, including fidelity, altruism, and compassion.

Yet at the same time our trainees learn a far different message from the medical culture they encounter in hospitals and clinics. In their day-to-day experience over many years of medical training, they encounter a tacit or hidden curriculum that presents a completely different perspective. The hidden curriculum says that *real* medicine is based only on “objective” data—numbers, graphs, and images—while “subjective” data—the patient’s story—lacks value because it lacks quantification. In other words, what patients feel, the suffering they experience, and the disability that haunts them, all of which they describe through the medium of words, are secondary in importance to physiologic quantities that can be directly observed. Thus, most of the clinician’s energy is devoted to tracking down and treating organ-based disease with little energy left over for the personal, social, cultural, or spiritual dimensions of illness. There is no need to pay attention to *who* the patient is. In fact, according to this view, patients often obstruct *real* medicine by introducing subjectivity into the clinical encounter; for example, they are “poor” historians, or they camouflage the needed data with unruly emotions and beliefs.

Clinical students soon learn to spend less time listening to the patient’s story and more time among their peers agonizing over the meaning of laboratory values. Trainees learn to accept responsibility for how well (or how poorly) they perform a bone marrow aspiration, interpret an x-ray, or maneuver a colonoscope. After all, they recognize that these procedures require technical skills that must be learned, and it wouldn’t make sense to blame the patient for an inadequately performed colonoscopy. Nonetheless, we commonly blame the patient for poor interview outcomes, stating with little room for doubt that, whether as a result of illness or education, anger or orneriness, the *patient* is a poor historian.

Stories of sickness and suffering—the kind of human stories that initially move us to enter a healing profession—gradually recede to the background as we become socialized into the technical culture of health care. Students and professionals preoccupy themselves with technical stories in which organs and instruments rather than people are the main protagonists. Sometimes, in fact, the patient’s personal narrative is entirely forgotten.

Today it is common in clinical practice for investigations to bring unexpected results to light, and these, in turn, lead to more investigations along a sidetrack. After a while the clinical team is interested in, say, the incidental finding of a renal cyst on an abdominal MRI, while the cyst may have nothing to do with the patient’s illness. The patient may have

trouble getting anyone to pay attention to what he *feels* and *believes* and *experiences*. At some point, after multiple diagnostic tests and specialist consultations, the patient cries out, “*But you haven’t done anything about my fatigue!*”

Yet this narrow, reductionistic way of thinking is not the only concept of medical practice available to us. At the same time, medical curricula and experienced clinicians continue to teach (and to model) a holistic, patient-centered brand of medicine in the tradition of the great clinician and educator William Osler, who 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.”

The Oslerian tradition has gained ground in recent years for several reasons. Well-intentioned clinicians have discovered that highly specialized, machine-intensive medicine is not necessarily the best medicine. Patients often find themselves doing better by the numbers, but still feel dissatisfied and sick. Worse yet, they may experience iatrogenic morbidity, and even mortality, as a result of poorly coordinated care or medical mistakes. In today’s culture people expect remarkable outcomes from medicine and frequently find themselves angry and confused when the system fails them. At the same time, studies have shown that good clinician-patient communication leads to better clinical outcomes and more satisfied patients, while poor communication leads to poor clinical outcomes, dissatisfaction, and malpractice litigation. In fact, when an adverse event occurs, clinician insensitivity is a major factor in a patient’s decision to sue.

Clinicians have begun to understand that pain, suffering, and dysfunction must not only be *conceptualized* in broad human terms, but also it must be translated into *action* if we are to be effective healers. Effective clinical practice requires that health professionals, no matter what their specialties might be, develop core competencies in communication and clinician-patient interaction. In other words, the *culture* of teaching hospitals and clinics must be changed so that the conflict between the explicit (courses and formal teaching) and hidden (everyday clinical experience) curricula is lessened or eliminated.

In the graduate arena, the Accreditation Council for Graduate Medical Education (ACGME) has tackled this problem by adopting a requirement that specifies core clinical competencies be taught in all residency programs. In order to be accredited, residency training programs of all specialties must develop curricula to address core competencies in six domains: patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based

practice. These broad categories include numerous intermediate level skill sets that relate to patient-centered medicine—for example, caring and respectful behaviors; clinical interviewing; informed decision making; listening skills; creation of therapeutic relationships; advocacy for patients within the health care system; and sensitivity to cultural, age, gender, and disability issues. The ACGME requires that residencies not only teach these competencies in a formal way, but also conduct performance-based evaluations of their residents.

The American Association of Medical Colleges (AAMC) has adopted a similar core curriculum project, as has the American Board of Medical Specialties. In the AAMC project, medical professionalism and communication in medicine are two of the five required domains; once again, interviewing skills are critical. In fact, the National Board of Medical Examiners has recently adopted a new examination (Step 2—Clinical Skills) to evaluate the student's ability to interact with patients, construct an accurate medical history, and engage in an effective clinical decision-making process. This examination, which utilizes a series of standardized patients, is predicated on the strong relationship between a student's interactive skills and the quality and quantity of data gathered in the interview.

This book is based on the premise that good clinician-patient communication is essential to good health care. Talking with patients is not a skill reserved for such specialists as psychiatrists, psychologists, and social workers. Medical interviewing is a basic clinical skill. It is essential for radiologists as well as internists, ophthalmologists as well as pediatricians, physical therapists as well as nurse practitioners. Interviewing skills are not a matter of common sense, nor do they necessarily develop with experience. These skills can be broken down into component parts, and they can be learned.

We contend that the medical history is a shared project, and the clinician bears a great deal of the “historian” responsibility. Too many times, “The patient is a poor historian” actually means “The clinical history is unclear because *I'm* a poor historian.”

The book is divided into three parts. Part One, *The Patient's Story*, presents fundamentals of clinical interviewing (Chapters 1 and 2) and various components of the medical history (Chapters 3 through 8).

Part Two, *Basic Skills in Practice*, applies these interviewing skills to the clinical office setting (Chapter 9) and for use with children and adolescents (Chapter 10), older adults (Chapter 11), and persons from different cultures (Chapter 12).

Finally, Part Three, *Challenges in the Interactive Process*, considers

difficult clinician-patient interactions (Chapter 13), telling bad news (Chapter 14), alternative and complementary approaches to health care (Chapter 15), ethics and professionalism in interviewing (Chapter 16), avoiding malpractice litigation (Chapter 17), patient education and negotiation (Chapter 18), and, finally, an example of the medical interview at work (Chapter 19).

In *The Medical Interview* we invite you to join in the exciting project of becoming a better historian and a more effective healer. This book is addressed primarily to students of medicine and other health professions who are just beginning their professional interaction with patients. However, it is also designed to serve as a resource for those who are further along in their education, including postgraduate trainees. Our particular emphasis is on microskills of the patient interview. Although we deal most extensively with basic history taking, we also illustrate how these same skills are building blocks for all types of clinician-patient interactions. They lie at the core of the art and science of medicine, where the patient's narrative is central.

CHAPTER 10

Pediatric and Adolescent Interviewing



Headed in the Right Direction

Stuart rose from the ditch, climbed into his car, and started up the road that led toward the north. The sun was just coming up over the hills on his right. As he peered ahead into the great land that stretched before him, the way seemed long. But the sky was bright, and he somehow felt he was headed in the right direction.

E. B. White, *Stuart Little*

UNDERSTANDING THE PEDIATRIC AND ADOLESCENT INTERVIEW

Why devote a separate chapter to pediatric and adolescent interviewing? Are the medical histories of children and adolescents that different from those of adults? In the following pages, we take the perspective that children and adolescents are not merely “miniature adults.” Not only is the style of a pediatric interview different from the style of an interview with an adult, but the style of the pediatric interview also varies dynamically from one developmental stage of childhood to the next.

CHILDREN VERSUS ADULTS: SIMILARITIES AND DIFFERENCES

There are, of course, many similarities between pediatric and adult medical interviews. For example, the basic organization of a clinical history is the same for patients of all ages: chief complaint, history of present illness, past medical history, family history, patient profile, and review of systems. Similarly, skills and values that facilitate good adult interactions—

such as empathy, respect, and genuineness—are equally important in pediatric patients.

There are, however, important differences between the adult and pediatric interview; these differences include the individuals who participate in the conversation and the topics emphasized at different stages of development. Parents or other family members often provide much of the information. Although this need is obvious in the case of a young child, the precise point at which a child has the skill to contribute his or her own story is not always easy to determine. With regard to topics, the prenatal history, for example, is vitally important in the case of a neonate but less so in the case of an adolescent. And the achievement of developmental milestones, which is critical to the routine assessment of a 6-month-old infant, is of minimal significance in the evaluation of a “straight A” second grader who presents with a sore throat. Trying to sort through the requirements of different developmental stages and the demands related to the reason for the visit can be confusing if not downright overwhelming. What do I need to know about this child today? (Fortunately, you can maintain the same open-ended approach to the interview as you do with your adult patients and let the child and person[s] accompanying the child be your guide.)



PRACTICE POINT

Open-ended questions allow you to sit back and size up the situation—the reason for the visit, the child’s behavior, the parent or guardian’s level of concern—while you plan your approach to the interview.

SETTING THE STAGE FOR EFFECTIVE COMMUNICATION

Comfort and Privacy

A private and comfortable environment is essential to the pediatric interview. If the patient is in a hospital room with several beds and the neighbor’s television is turned on, visitors are chatting, and medical personnel are performing procedures, then families will feel uncomfortable talking about even mundane historical items, much less about giving thoughtful observations of behavior or potentially embarrassing details. Before starting, suggest that the television and radio be turned off and, if possible, roommates be taken elsewhere by their parents or by staff members. Otherwise, draw curtains around the child’s bed to provide at least the

illusion of privacy. Similarly, you should see that an infant is comfortable and quiet (usually in a loved one's lap) before expecting the parents to be relaxed enough to provide you with detailed information.

Establishing Rapport

In the case of a preschool child, offering the patient a toy to play with may well improve the efficiency of an interview. At the beginning of an interview, establish rapport with the patient and family members. For example, with a newborn's parents, spend a few moments admiring the baby; with the a 2-year-old toddler, try to charm him or her before interviewing the mother; with the school-age child, ask him or her about a favorite television show or after-school activity.



PRACTICE POINT

With children it is often easier to establish rapport *indirectly* by admiring a toy or a pair of new shoes rather than greeting the child too enthusiastically.

Spend a few moments talking to the parent or guardian to give the child time to size you up (while you size up the child as well). Here's how one clinician observes his 4-year-old patient.

Clinician [Entering quietly and looking first at the child's mother]: Hi there. So how's he doing?

Patient [Mother]: He seems fine. He did really well with the medicine. [Mother is sitting on the examination table and the child is walking around the room.]

[Child]: I want you to look at mommy's ears.

That's a good idea. Would you like to help me?

[Child]: Okay.

You can hold my stethoscope [handing it to child] while I get the light [reaching for otoscope]. [Looking in mother's ears] These look good. What about your friend Winnie the Pooh—can I look in his ears next? [Child hands stuffed toy bear to clinician.] They look good, too. Do you want to see? Now I can look in your ears, they look excellent. Very good. You did a very good job.

Notice how the clinician gives this child time to size up the situation and provides an opportunity for the child to become familiar with potentially scary maneuvers. Sometimes the examination room becomes a

three-ring circus when parents bring more than one child. In these situations, do the best you can to maintain your focus and use the opportunity to observe how the parent or guardian sets boundaries and expectations for the children. These observations take no additional time and become a part of your assessment of the child.

Understanding Relationships

Make no assumptions about the relationship of the caretaking adults to the child patient. The parents of an infant may not necessarily bear the same married name. Thus, the term “his father” rather than “your husband” or “the baby’s mother” rather than “your wife” might be more appropriate until the parental relationship is better understood. Similarly, an infant and his or her parent may not carry the same surname. A brief glance at the registration form might reveal that the infant’s name is Doe, while the mother’s and father’s name is Smith. Because you need to understand the relationship for the benefit of the child, it is best to ask, simply and nonjudgmentally, “I notice that your name is Smith and William’s name is Doe. Can you explain the relationship to me?”

Finding the Right Words

Finally, tailor your vocabulary to the level of understanding of the family members with whom you are speaking, although discernment of their verbal and clinical sophistication is subject to bias and may at times be difficult. Consider this aspect, too, in speaking with the child, who will understand more than you may expect if you use appropriate words. For example, you could say to a parent, “Tell me about this rash.” But you can say to a child, “Do you have any spots?”

TALKING WITH PATIENTS OF DIFFERENT AGES

The style and content of a medical interview vary enormously with the child’s age as well. The questions you ask new parents about their baby will be different from those you ask a teenager. The content of the medical history changes with age, just as the style and dynamics change. Topics that are obviously important in the prenatal visit or in the newborn interview become distinctly less important as the child matures and, indeed, may not be mentioned at all in the medical conversation with an adolescent. For convenience, we distinguish four types of pediatric interviews: the prenatal visit, the infant or toddler visit, the school-age child visit, and, finally, the adolescent visit.

The Prenatal Visit

Ideally, the clinician responsible for the medical care of a newborn should meet with prospective parents before the birth. This **prenatal visit** allows the caregiver to obtain important medical information and establishes a partnership of mutual trust and respect. The diminished role of extended, multigenerational families means that in many cases the primary emotional and educational support for new parents may come from a clinician, rather than from family members. A brief, informal meeting initiates such a support system and dispels myths and misconceptions that the new parents might have. The information you acquire during this prenatal visit includes a detailed family history, the parents' knowledge about child care, and their plans for feeding the baby (breast versus bottle) and for circumcision (yes or no). Practical issues such as the schedule for well-child office visits, clinical fees, and telephone access can also be presented at this time.

During your meeting with prospective parents, obtain information about the family history: familial disease, previous histories of birth defects, and perinatal deaths. The purpose of this family history is twofold:

- To alert you to possible genetic disease in the infant as well as the parents' fears about such disease
- To reassure or inform parents concerned about implications for their child of certain familial illnesses or tendencies

Listen especially for details of miscarriages and neonatal or childhood illness or death; such tragedies have lifelong impact on families. The parents' health and their past medical history should be outlined in some detail, especially with respect to disease states that might endanger the life or health of the fetus during pregnancy. In this way, you are able to pay attention to the physical, social, and emotional environment into which the child will be born. Parents' discussion of their plans for feeding the baby and their knowledge of child care inform your educational efforts not only at the prenatal visit but also at subsequent well-baby visits.



PRACTICE POINT

The prenatal interview provides an opportunity to lay the groundwork for anticipatory guidance, which is the critical educational aspect of caring for children.

For example, take the opportunity to discuss issues such as:

- The parents' perceptions of changes that will occur in their lives with the newborn's arrival
- Identification of support persons for the mother and father when the infant goes home
- The parents' knowledge of safety for the infant at home and in the automobile
- How the parents view preparation of siblings for the new addition to their family

Sample Screening Questions at the Prenatal Interview, below, provides some typical screening questions that are useful at the prenatal visit.

WHAT TO SAY

Sample Screening Questions at the Prenatal Interview

- Have you had any problems with your pregnancy? Any extra doctor visits or special tests? Everything going normally?
- Do you have any special concerns or questions about having this baby?
- In your family, and in the baby's father's family, have there been any babies or children with problems or illnesses?
- Who is going to help you out at home when the baby arrives? Tell me what you're thinking about going back to work.
- Lots of new parents are pretty nervous about caring for their first baby. How are you dealing with that?

The Infant and Toddler Visit

During infancy and the preschool years, the child is the focus of the interview but is usually not a participant. Although the patient may add little to the actual conversation, the interview is usually conducted while the infant or toddler is present. This small but important person serves as a catalyst to aid parents' recall of historical details. Also, parents are likely to be more comfortable if they are with their child, and certainly the child will be more comfortable with the parents. And when the child sees you interacting with the mother or father, the child is more likely to develop a (very tentative) feeling of trust.

A child who is fussy or in pain will only distract both you and the parents, however. The situation can be remedied with a pacifier or bottle for the infant or a familiar toy for the toddler. It is useful to carry around a colorful item or two to interest your preschool patients. Sometimes inexperienced clinicians either ignore the patient completely (to the consternation of parents) or try to become instant “buddies” with the child, forgetting that by age 1 most children are quite wary or even frightened of strangers. Moreover, illness may make the toddler irritable, and the clinical setting may be terrifying.



PRACTICE POINT

A good compromise during the infant/toddler visit is to begin the encounter with a simple, friendly greeting, followed by the enthusiastic but brief examination of one of the child’s toys.

The medical history information about the perinatal period should include:

- Complications and problems during the pregnancy and labor (e.g., “Did you have any problems during your pregnancy or with your labor and delivery?”)
- Problems during the first days of life (e.g., “Did Zack have any problems when he was born?”)

If it has not already been obtained, you should take a careful family history as well. Ask about the child’s crying, sleeping, and bowel and bladder function. Ascertain the child’s immunization status, including reactions to the immunizations. Carefully review developmental stages, focusing on different milestones depending on the age of the child, and try to get a sense of the child’s temperament (e.g., regular versus irregular habits, mellow versus intense reactions).

Here’s how one clinician performs a quick developmental screening of a 6-month-old:

Clinician **So. It’s good to see you. You look as if motherhood is agreeing with you, but I know it’s hard work. How’s Jacob doing?**

Patient [Parent]: He’s doing really well. He’s easier than Elizabeth was. He’s very predictable, although sometimes in the middle of the night he wants to play.

He looks like a playful character and he clearly loves his mommy, and I can see he’s not too sure about me. What’s he doing for you?

[Parent]: Well he's rolling over both ways and if I sit him up he can stay there. Everything goes in his mouth.

That all sounds very normal. Have you ever seen him pass something from one hand to his other hand?

Notice how the clinician provides the parent with support and positive feedback and progresses from open-ended to more specific questions, building opportunities for anticipatory guidance even during this information-gathering phase of the encounter.



PRACTICE POINT

Avoid leading questions, such as “Doesn’t he sit up yet?” that create needless anxiety (if he’s *not* sitting up yet) and inhibit true answers and sharing of concerns.

Sometimes a developmental history can be accomplished with a single question when there is an older normal sibling: “Tell me how Jacob has been for you compared to Elizabeth.”

Nutrition questions are also important in your clinical history. A few screening questions often suffice:

- “How many ounces of formula [or, for older children, milk] does your baby take each day?” For breast-fed babies, “How many times does the baby nurse in 24 hours?” and “What’s the longest he or she goes between feedings?”
- For older infants and toddlers, “Are there any foods your child refuses to eat?”
- “Does your child get much in the way of sweets and fast food?”



PRACTICE POINT

Because anticipatory guidance plays an important role in every interaction in this age group, try to obtain enough information to anticipate later discussions of accident prevention, feeding, toilet training, teething, and acquisition of normal speech patterns.

Here’s how one clinician began her closure of a newborn well-visit by summing up her findings, showing her appreciation of the infant, and receiving back from the baby’s mother a statement which, despite its brevity, indicates much about the family’s culture and point of view:

Clinician [Admiring the infant] **He's perfect. How did you get so lucky?**

Patient I'm blessed.

The content of the interview varies with the reason for the visit: well-child care, an office visit for illness, a sick child in the hospital, or a child about to have a surgical procedure. The child's demeanor and the parents' level of anxiety and ability to provide precise information about the child's illness will vary. Parents may be extremely focused on whether they have cared for their child correctly or have done anything to provoke or worsen an illness.



PRACTICE POINT

During the interview with a pediatric patient, convey that the parent is a good parent.

When the clinician asks about the child's behavior and milestones, parents may see their skills being challenged. If so, they may give "ideal" answers, even though they would like to share their fears and worries. Sometimes, especially early in the interview, you may be unable to provide such reassurance and may need to say:

Clinician **I understand your concern about whether you should have given Molly that cold medicine, but I'd like to leave that aside for the moment and get back to how she's been acting over the last few days. When did you first notice that she wasn't her usual self?**

Once you have established the history, you will be able to reassure the parents that they have not hurt their child or, alternatively, to educate them in the proper care of a sick child.



PRACTICE POINT

The symptoms of pediatric illness, particularly in the preverbal child, are often nonspecific and tell us more about how sick the child is than about precisely what the illness is.

A 15-month-old cannot tell us that his or her left ear hurts; rather, he or she will cry, be irritable, have a fever, and possibly have a loss of appetite or even vomiting and diarrhea. If we are lucky, the child may tug at the affected ear, but many children with healthy ears do that as well.

We have to rely on our physical examination to make the diagnosis of left otitis media. But if the child is exceedingly irritable, refuses to play, and refuses liquids, we may need additional diagnostic studies to rule out more serious illness such as meningitis. Table 10–1 lists the key information required in the infant and toddler interview.

Typical Screening Questions at the Infant and Toddler Visit, page 203, provides some typical screening questions that are useful at infant and toddler visits.

TABLE 10–1

CONTENT OF THE INFANT AND TODDLER INTERVIEW	
<i>Reason for Visit</i>	<i>Topics Discussed</i>
Well-Child Visit	<ul style="list-style-type: none"> • Parental concerns • Prenatal and birth history • Developmental milestones achieved • Dates of prior immunizations. Is child current? • Eruption of teeth • Habits: sleeping, crying, and bowel and bladder function • Intercurrent illness and other illnesses • Nutrition history • Cultural and family practices (feeding, taping umbilical hernias, keeping face covered to prevent colic)
Sick Visit or Admission to Hospital	<ul style="list-style-type: none"> • All of the topics discussed in a well-child visit • History of Present Illness (see Chapter 3, Chief Complaint and Present Illness) with special emphasis on time of onset, initial symptoms, and subsequent symptoms • Difficulty feeding—too slow, not at all, refusal of liquids or solids, or preference for water or juice as opposed to milk or formula • State of hydration. When was the last wet diaper and how wet was it? • Does the infant or child seem himself or herself? Playful, alert, pleasant, or acting sick? • Temperature taken at home? (Rectal? Axillary?) • Medications (including over-the-counter) already given and dosages? • What concerns the parents most? What do they think is causing the illness? • History of recent similar illnesses in patient or family?

WHAT TO SAY

Typical Screening Questions at the Infant and Toddler Visit

Ask the screening questions related to the prenatal visit if not previously done.

- Did you have any problems with your pregnancy or with your labor and delivery (getting this baby born)?
 - Did the baby have any problems when he was born? Go home with you at the usual time?
 - (To screen for temperament) Tell me what kind of baby she is.
 - (To screen for developmental milestones) What's she doing for you?
 - Tell me what a typical day is for him, with eating, sleeping, wet and dirty diapers.
-

The School-Age Child Visit

When a child reaches age 5 or 6, the interactive balance in the interview begins to change. Children are now more able to contribute substantially to the collection of data, but their reports are usually broad and sometimes difficult to interpret. Thus, you must turn to parents to provide accuracy and precision, while always trying to confirm the data with the small patient insofar as is possible. An enormous maturational range is found in elementary school-age children. You can expect to find behaviors ranging from shy, sullen, and silent to that of the garrulous child who cannot be stopped.



PRACTICE POINT

As a sensitive interviewer, you must take your cues from observing the patient before deciding whether and how much to involve the child in actual history taking.

In general, the school-age child is a healthy child. Well-child visits emphasize historical information concerning immunizations, development, and nutrition, as well as the psychosocial aspects of a child's environment. Knowledge of the child's school performance and friends is necessary for the global understanding of a school-aged child's well-being. Anticipatory guidance at this age emphasizes accident prevention,

TABLE 10-2

CONTENT OF THE SCHOOL-AGE CHILD INTERVIEW	
<i>Reason for Visit</i>	<i>Topics Discussed</i>
Well-Child Visit	<ul style="list-style-type: none"> • Parental concerns • School progress, school readiness, relationships with peers • Developmental milestones achieved? At what age? • Habits (eating, sleeping, continence) • Age-appropriate play? • Similarities to and differences from peers • Significant past and birth history • Illnesses since last visit • Nutrition • Dates of prior immunizations
Sick Visit or Admission to Hospital	<ul style="list-style-type: none"> • All of the topics discussed in a well-child visit • History of Present Illness (see Chapter 3, Chief Complaint and Present Illness) with special emphasis on parents' observations • Child's description of symptoms • Medications (including over-the-counter) already tried • Similar illnesses in household or peer group

both in the home and at school, and good nutrition. Special aspects of the content of the school-age child interview are indicated in Table 10-2.

Typical Screening Questions for the School-Age Child, below, provides some typical questions that are useful for the school-age child.

WHAT TO SAY

Typical Screening Questions for the School-Age Child

- Tell me how school is going for you.
- What's your favorite subject? Do you think your teachers like you?
- What do you do after school?
- (To the parent or guardian) Do you think she is at the same level as her classmates and friends?
- (For a sick visit) Anyone else at home or at school have any symptoms like this?

The Adolescent Visit

Your interactions with teenagers are potentially the most complicated and difficult of any interviews you will conduct. Because the adolescent person is frequently ambivalent or confused by his or her own feelings and resists talking about them, you will likely notice a lot of silence during these interactions.



PRACTICE POINT

In the patient interview with an adolescent, the yes/no and other types of closed-ended questions will yield extremely brief answers that leave you struggling to come up with more questions.

Moreover, during the adolescent years, patients take an increasingly active role in their own health care, while their parents move progressively into the background. This is a change that many mothers and fathers, as well as their teenage children, find difficult.

You may initiate the interview with an unfamiliar teenager with a direct, unaffected introduction:

Clinician **Hi, I'm Dr. Smith and I'm glad to meet you. Tell me what made you decide to come to see me or why your parents made you come in.**

Sit down and meet the teenager at his or her level with eye contact that allows for natural breaks.



PRACTICE POINT

Remember that initially you are a stranger and must establish a basis for trust.

Many clinicians try to become instant friends with teenagers, succeeding only in confusing or antagonizing them. It is important to be the person you are (see "Genuineness" in Chapter 2): if you are not "cool," don't try to be. It is appropriate to talk with adolescents alone for part of the interview, if not for the whole interaction. Most parents are cooperative and will leave the examination room without difficulty when you explain why, for example:

Clinician **You know how important it is for you to feel that you have a private and confidential relationship with your doctor? Most of**

my young patients feel the same way. So I'm going to ask you to leave while I talk with Jamie. Is there anything you'd like to tell me before you go?

When speaking with an adolescent, establish that your conversation is confidential. Whether the information is potentially embarrassing or not, build trust by assuring the patient. For example:

Clinician I always want to make it clear to all my patients that what they tell me is private. I will not repeat anything you say unless you give me permission to do so or I'm worried about you and we need to tell a responsible adult, like if you get very sick or something. But you know, your Mom cares about you and may have some concerns about what we do today. If she asks me anything, in order to protect your privacy, I'm going to tell her that she needs to ask you. So you might want to think about what you'd like to tell her, and we can talk about that some more at the end of our visit.

The statement above not only nourishes the adolescent's desire for autonomy, but it also acknowledges the parent or guardian's rightful interest in the child who has not yet achieved full adult status. It also implies that parents and their children should talk about important topics, even those that are difficult, such as sexuality.

Important information to obtain from the teenager centers around the teenager's interaction with his or her environment and social world. In a sense, the patient profile or social history is *the* history in the adolescent. Tactfully posed questions dealing with drugs and alcohol, safety, sexuality, contraception, and sexually transmitted diseases are an important part of a medical history in this age group. But even the most tactful interviewer often has difficulty breaking through the outward reserve that many adolescents display. If this is the case, posing sensitive questions in the past tense is sometimes helpful. For example, rather than asking, "Do you smoke cigarettes?" you might ask, "Were you smoking cigarettes 6 months ago?" This avoids direct confrontation. Here is another example of how you might "open up" a silent and possibly angry adolescent interview.

Clinician I'm sorry that your father dragged you in here against your will. I know if I were in your shoes I'd be pretty angry. But since we have this time together, do you think we could talk about some

of the things that have been going on in your life? None of this is any of my business unless it's okay with you for me to get to know you better. I'd like to hear more about how you've been feeling.

Other important issues to discover during the interview include:

- School performance
- The presence or absence of close friends
- Behavioral difficulties both at home and at school
- Stress and stressors, and symptoms such as anxiety or depression.

Ideally, you should obtain most of this information directly from the adolescent rather than from a parent or guardian. Topics important to review during the visit with the adolescent patient are listed in Table 10–3, and *Typical Questions and Statements to Engage the Adolescent*, page 208, provides some helpful screening questions and statements to engage this patient.

TABLE 10–3

CONTENT OF THE ADOLESCENT INTERVIEW	
<i>Reason for Visit</i>	<i>Topics Discussed</i>
Well Visit	<ul style="list-style-type: none"> • Parental concerns and confidentiality in the clinician-patient relationship • School progress and peer relationships • Habits (eating, sleeping, physical activity) • Smoking, alcohol, and drug use • Sexuality and sexual activity • Past history (illnesses, medications, allergies) • Interval history (any illness or symptoms since last visit) • Immunizations (and related childhood diseases)
Lay the groundwork for anticipatory guidance:	<ul style="list-style-type: none"> • Diet and exercise • Injury prevention (bicycle, motor vehicle, firearms)

(continued on following page)

TABLE 10–3 (Continued)

CONTENT OF THE ADOLESCENT INTERVIEW	
<i>Reason for Visit</i>	<i>Topics Discussed</i>
Sick Visit	<ul style="list-style-type: none"> • Smoking, alcohol and drug use • Sexuality, contraception, unintended pregnancies, sexually transmitted diseases • Stress, depression, hopelessness
	<ul style="list-style-type: none"> • Reason for coming (parents' view, adolescent's view) • History of Present Illness and related Review of Systems • Boundaries of confidentiality (what parent needs to know when adolescent is sick) • Possible relationship of sexual activity and substance use to current symptoms • An abbreviated review of well-visit topics if the sick visit is also a first visit to the office

WHAT TO SAY

Typical Questions and Statements to Engage the Adolescent

- (With parent, at first, in the room) I like to have a private relationship with my young patients unless, of course, there is something that parents need to know. Do you have any questions or concerns about that?
 - (To the parent) Are you okay with stepping out while we talk and I do my exam? Then I can have you come back when we're done.
 - Here comes the sex and drugs. It's my job to ask you those hard questions about smoking and sex and drugs and your safety. Are you doing any of that? Tell me more about that.
 - The reason I ask is that these things are important to your health and I want you to take responsibility for being healthy. And if you have any questions, you can ask me. Like I know you're not having sex now, and I will tell you that having sex is not a good idea. But if you do have sex I want to make sure you don't get pregnant or get sick, like with AIDS or something.
-

The Adolescent Sexual History

The sexual history is a critical but particularly difficult topic for adolescents, which must be covered when there are genitourinary or gynecologic symptoms. It is also part of preventing and screening for sexually transmitted diseases and pregnancy. As with patients in any other age group, you should use clear language that the patient understands and proceed from less intimate questions (“Tell me about your family and friends.” “Do you have any special friends?” “How about boyfriends or girlfriends?”) to more intimate questions (“Do your friends go on dates?” “How do they feel about having sex?” “How do you feel?” “Are you sexually active now?”). If you are uncomfortable with these issues, it is okay to say so. Useful approaches include:

- “It may be an uncomfortable topic, but as your clinician I need to find out if you’re at risk for HIV and other illnesses.”
- “Do you have any questions about your body? About sex? About how not to get pregnant? Have you thought about birth control?”
- “Are your friends (or the kids at school) having sex? How about you?”
- “Some kids your age get pretty serious about relationships and start having sex. How about you?”



PRACTICE POINT

Adolescent patients should be given time to respond and allowed to answer in their own way with your assurance that the information is confidential.

Teenage males should be queried about their risk of getting someone pregnant, just as teenage females should be asked about their personal risk of pregnancy.

One problem, of course, is making sure that, when you use a term such as “sexually active,” the patient understands what you mean. Young teenagers vary widely in their sexual knowledge and experience; among 14-year-old girls, you will find those who have already been pregnant and others who will look wide-eyed and disbelieving that you could even think of asking such questions. For this reason, questions about their peer group as well as questions that do not imply any right answer or particular level of experience are useful. For example:

Clinician Some girls your age who are late with their period will worry that they may have gotten pregnant. Have you had any worries like that?

Patient No, because I know I can't be.

You can't be. Tell me more.

Well, I didn't have sex. I don't even go with boys; none of my friends do.

Sometimes the conversation takes a different turn:

Clinician Some girls your age who are late with their period will worry that they may have gotten pregnant. Have you had any worries like that?

Patient Well, I thought about it.

Tell me more.

Well, I don't really think I can be.

Did he touch you or did he put his penis near you or inside you?



PRACTICE POINT

It's important to be simple and precise in your language so that you can be sure that you are obtaining accurate information.

SUMMARY—Pediatric and Adolescent Interviewing

Even the toddler can provide important data in the history, and many older children do not require intermediaries to transmit their stories.

To make the most of your interactions with pediatric patients, be sure you:

- Approach the young child indirectly by first admiring a toy or item of clothing
- Understand the parent or guardian's view of the illness to lay the groundwork for assuring them that they did not cause it
- As children get older, involve them more and more in the interview, choosing words they understand
- Help families understand common problems and developmental milestones, laying the groundwork for anticipatory guidance

To make the most of your interactions with adolescents, be sure you:

- Establish the confidential nature of your relationship, as well as its limits and boundaries
- Avoid yes/no type questions that tend to produce brief responses ending, ultimately, in silence
- Address topics such as drug and alcohol use, sexuality, and safety