INTERVIEWING STRATEGIES
A.K.A.
HOW TO GET PEOPLE TO TALK TO YOU!!

WHAT ARE WE TRYING TO ACCOMPLISH?

YOUR GOAL
✓ Collect complete and accurate info
✓ Begin a relationship with this person
  + involves trust
  + hopefully will continue to grow over time
✓ Help them learn about their health

MUTUAL GOAL
Optimization of their health

Comprehensive Health History

Subjective
✓ Something a person chooses to tell you
  + How he/she perceives their health
✓ Remember: they may edit their information (a lot!)
  + They remain in control of this area
✓ It takes skill to gather the information you feel is important
BEGINNING BASICS

Introductions
- What was your name again?

Setting
- Your demeanor
- Your dress
- Your greeting
- Note taking

Non-verbal messages
- posture, gestures, eye contact, tone of voice, facial expressions

Be alert to special patient needs:
- developmental needs
- disabilities
- cultural issues
- highly emotional situations

Effective Questioning...

Use open questions
Try direct questioning
- location, quality, quantity, chronology, setting, provocative, palliative, associated factors

Interpret
Summarize

Effective Questioning Pt 2..

Things to try...
- Silence
- Clarification
- Reflection
- Reassurance
- Support
- Confrontation

Things to avoid...
- yes-no questions
- complicated medical terms
- multiple questions
Special Communication Skills

1. This is NOT like talking to your friends!
2. Active listening is much more important than talking
3. Watch your language (& speech patterns!)
4. Try some introspection...

10 TRAPS

1. Giving false assurance or reassurance
2. Unwanted advice
3. Abusing your “Power” or authority
4. Using avoidance language
5. Distancing yourself
6. Overuse of medical terminology
7. Asking leading or biased questions
8. Talking too much
9. Interrupting
10. Asking “why”

As you exit...

∑ Summarize the communication
   + (as you remember it!!)
∑ Ask that final question (get ready,)
   + “Is there anything else you’d like to tell me”
   + “Anything else I should know to help in planning your care?”
∑ BAMM!! The door knob phenomenon...
   + “Well, there is one thing...”
   + The most helpful information often comes during the last 30 seconds...
Some final thoughts...

WHAT DOES THE PATIENT BELIEVE IS HAPPENING TO THEM?
WHAT DO THEY THINK WILL MAKE THEM BETTER?

Where the rubber meets the road: Effective Charting

Getting it down on paper is really the toughest part of the whole process...
- What pieces go where?
- What is a “nice to know” and what MUST be included?
- What’s the standard “industry” format?
- What words do I use?
- How to be complete and still brief...

DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>REQUIRED</th>
<th>NICE TO KNOW</th>
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</thead>
<tbody>
<tr>
<td>Pt identification</td>
<td>Marital status</td>
</tr>
<tr>
<td>Date of exam</td>
<td>Education</td>
</tr>
<tr>
<td>Age</td>
<td>Occupation</td>
</tr>
<tr>
<td>Race</td>
<td>Reliable source of information?</td>
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<tr>
<td>Sex</td>
<td>Nationality</td>
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<tr>
<td></td>
<td>Place of birth</td>
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<td>Referred by</td>
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</table>
CHIEF COMPLAINT (CC)

✓ A statement written in “quotations” stating why the patient is presenting to you for care
✓ “I’m here for an annual exam”
✓ “I have a sore throat”
✓ “I’m here for a Blood Pressure check”
✓ “I’m scheduled to have my gallbladder taken out today”
✓ “My daughter is pulling on her ears, I think she has another ear infection”

HISTORY OF PRESENT ILLNESS (HPI)

✓ The HPI is written in a narrative format
✓ It contains information concerning the Chief Complaint and any RELEVANT concurrent medical problem
✓ The problem should be described both
   ✓ CHRONOLOGICALLY
   ✓ and in
   ✓ APPROPRIATE DETAIL

HPI (2)

✓ Relevant means:
   ✓ information necessary to further clarify the chief complaint
   ✓ information that helps contribute to making the diagnosis
✓ Concurrent means:
   ✓ first episode to present
   ✓ describe the impact of the illness on the patient
HPI (3)

- Appropriate detail means:
  - full characterization of the symptoms
    - Quality, quantity, location, radiation; precipitating, aggravating and relieving factors
  - Any and all other information that may relate to the CC should be addressed
    - Personal, life style, travel, environmental, occupational

PAST MEDICAL HISTORY (PMH)

- This section deals with MAJOR problems that:
  - have resolved
  - are currently inactive
  - active but currently stable
- Active problems pertaining to the HPI should be discussed in that section
- Unrelated problems with symptoms should be recorded in Review of Systems

PMH (2)

- General Health
  - How they see their health
    - excellent, good, average, poor, etc
  - Can they perform ADL's?
  - Live independently?
  - etc...

- Childhood illnesses:
  - childhood conditions that may have long-term sequelae
  - infections
  - developmental
  - traumatic
  - fractures
PMH (3)

- Adult illnesses *
  - infections
  - cardiovascular
  - GI
  - Misc:
    - DM, CVA, CA, Anemia, Thyroid, Renal, Derm.
- Each disease should be asked about and if present, clearly documented

PMH (4)

- Obstetrical History*
  - Mode of delivery
  - Complications
  - Gravidity = Lifetime total number of pregnancies
  - Parity = Term, Preterm, Abortion, Living
- “24 y/o G1 P1001, uncomplicated vag delivery”

CURRENT HEALTH STATUS

- Medications - Rx
  - Generic name
  - Dose
  - Duration
  - Reason for use
  - Compliance
- Medications - non-Rx
  - What used
    - sleep, diet, NSAID, antacids, laxatives, cold medications
  - How often
  - Last used
  - Effectiveness
FAMILY HISTORY (FH)

- Use of a genogram helps tremendously here. Be sure to include:
  - Key
  - Identify patient
  - Note ages of family members
  - Note if they are living or deceased
  - Specify if possible, cause of death
  - List familial diseases

FH (2)

- Ask about the following diseases (add more as needed)
  - DM
  - CA (esp. breast, colon, prostate, ovarian)
  - Rheumatologic disease
  - Renal disease
  - HTN
  - Atherosclerotic disease
  - Emotional disorders
  - Abuse (Substance, Child, Spousal; verbal, physical)

PSH

- General outlook on life - present/future
- Living Situation
  - Type housing
  - # people in home
  - relationship to pt
  - # of bathrooms
  - Heating/cooling
  - Steps
  - Phone
  - Problems

- Occupation
  - Employed?
  - Current work situation
  - Type of work/position
  - Reason for change
  - Exposure to hazardous materials (asbestos, radiation)
  - Child care provider?
  - Spouse employed?
  - Retired
### PSH (2)

- **Financial Status**
  - combined salary
  - Social Security
  - Welfare, ADC
  - Total In = Total Out?

- **Recent Stressors**
  - death
  - illness
  - financial
  - school (grad school?)

- **Sources of Anxiety, Guilt etc.**
  - financial
  - family
  - occupation
  - health

- **Ever sought counseling?**
  - type
  - duration
  - success?

### MILITARY HISTORY

- Consider asking about this:
  - Rank
  - Responsibilities
  - Previous assignment details:
    - geographic locations
    - duration
    - dates

### REVIEW OF SYSTEMS (ROS)

- Final, systematic checklist to make sure that no significant problem has been overlooked
- Clearly instruct patient:
  - yes-no answers
  - clear time frame (1 year, 6 months, lifetime)
- Active problems NOT related to HPI should be addressed here
- Any major new problems needs to be addressed separately
SEQUENCE FOR PE WRITE UP
1. Vitals (P: rate & rhythm, BP: location & position)
2. Skin (general condition & specific lesions)
3. HEENT
4. Neck
5. Chest & Lungs
6. Cardiovascular
7. Breasts
8. Abdomen
9. Musculoskeletal
10. Lymph Nodes

SEQUENCE (cont)
11. Neurological (including Mental Status)
12. Genital (rectal and occult blood findings noted here in female exam)
13. Rectal (prostate and occult in male exam)

ASSESSMENT
This is where you really have to “commit yourself” on paper (for the entire world to see)!!
Keep it BRIEF - 2-5 words is plenty
When looking at a note, most providers START here and then go backward to review the objective and subjective data.
People usually save the “Plan” for last.
ASSESSMENT (CONT)

Some Sample Assessment Statements:
- F/U HTN
- Rt Otitis Media
- Bacterial Conjunctivitis
- NL GYN exam
- R/O MI
- R/O Appendicitis
- Rt Ankle Strain
- Pre-op Physical - NL findings

PLAN
Systematically Written:

1. Diagnostic measures you initiate:
   - CBC
   - Pap Smear
   - CXR
   - CT of the sella turcica
   - Abdominal MRI
   - Consult to Dermatology/Radiology etc..

PLAN (cont)

2. Pharmacologic Measures:
   - Flagyl 375mg po BID x5 days, NR
   - Amoxicillin 500mg po QID x10 days, NR
   - etc...

3. Therapeutic Measures
   - Physical Therapy QD x 2 wks
   - Splint stabilization Lt wrist
   - Acupuncture QOD
4. Teaching
   - In-depth Preconceptual counseling done: handouts given
   - Otitis externa prevention sheet given and explained
   - Breast Self Exam teaching done: handout given

PROBLEM LIST

This is VERY OFTEN forgotten by students: we look for this and grade it!!

All problems should be included:
- Physical, Psy-Social, Historical, Laboratory
- List problems in order of importance to CC
- Include active and chronic problems
- Should try to identify as MANY problems as possible for each patient

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<thead>
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<th>Problem #</th>
<th>Date</th>
<th>Problem</th>
<th>Active</th>
<th>Resolved</th>
<th>Initials</th>
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