The Medical Inquiry: Invite, Listen, Summarize

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Abstract

- *Objective:* To present a model for conducting a medical interview.
- *Methods:* Illustrative dialogue and discussion.
- *Results:* Observation of practicing physicians, residents in training, and medical students shows that most clinicians use a dominant mode of inquiry when talking with patients:a high-control barrage of closed questions. This approach wastes time, misses critical data, and alienates the patient. A better model, now used at the University of Colorado School of Medicine in teaching students the medical interview, emphasizes 3 components: Inviting a story, Listening effectively, and Summarizing periodically as the story progresses ("ILS"). Such a triad can be used over and over and largely replaces the physician-centered, high-control technique.
- *Conclusion:* The ILS technique can be taught, learned, and practiced and results in better data, more efficient use of time, and happier patients and clinicians.

Observation of practicing physicians, residents, and medical students shows that most clinicians use a dominant mode of inquiry when talking with patients: a high-control barrage of closed questions [1–4]. This style is so closely associated with physicians that when a group of fifth-grade students was asked to act as doctors and interview each other, many launched into a string of questions answerable only with either a "yes" or a "no" (R. Epstein, personal communication). Whether this behavior stems from the students' personal experience with physicians or from their conceptions of what a doctor should sound like, we believe the style is common among mature physicians and doctors-in-training and is a cause of much trouble in their care of patients. We suspect that avoidance of open-ended questions or patient-centered interviewing may stem from a fear of losing control of the interview or appearing unknowledgeable if they don't have the next pithy question ready to fire off. In any case, this mode of inquiry is inefficient, ineffective, and destructive of physician-patient rapport.

What does it look like? Consider this dialogue:

Pt: Hello, Dr. X. I'm George Washington.
Dr: Hello George, what brings you in to see us today?
Pt: Well, I've got trouble with my legs, down by my knees.
Dr: Your knees! Swollen? Painful?
Pt: Mostly they hurt, Doctor. But they're stiff too. And there's some swelling.
Dr: I see. And both equally? Or one more than the other?
Pt: Mostly the right one, I guess.
Dr: Any other joints bothering you?
Pt: No, just my knees.
Dr: OK, well we'll take a look at them.
Pt: OK, Doctor. And while you're doing that, could you listen to my chest too?
Dr: Your chest? Sure. Why do you mention that?
Pt: Well, it's just that my chest has been hurting here on the left side and I'm kinda worried about my heart.
Dr: Your heart! Have you had heart trouble before?
Pt: No, it's just that I was worried . . .
Dr: I see. And how long did you say your leg was troubling you?
Pt: Oh, that's just the last week or two.
Dr: Any other troubles? Cough? Shortness of breath? Coughing up blood? Fever?
Pt: Oh my goodness, no. No fever.
Dr: Well, let's get an x-ray of your knees and then we'll go from there.
Pt: OK. It's just that I'm a little worried because . . .
Dr: No need to worry. We'll look you over and see what we can do.
Pt: OK.

This physician may be quite competent and respected by his peers and yet oblivious to his style of interviewing and what it leaves undiscovered. Health care providers have many modes of conversing. They can direct the patient to a

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given area and ask to be told about it; they can ask questions—wide open questions or narrow closed ones; they can use directive questions that imply the sort of answer they would like or complex questions that tend to provoke an answer only to the last item mentioned; they can interrupt, disregard, argue, empathize, or sympathize. But they tend to use the sort of questions that Dr. X specializes in—narrow, closed, asking for a yes, no, or number as an answer. Watching University of Colorado medical students interview standardized patients (actors simulating a patient problem), we note that they adopt this mode of inquiry very early in their careers, even when they "don't know what questions to ask." But Dr. X was a more experienced physician and knew the questions he wanted to ask. Unfortunately, what he didn't do was hear the story that his patient wanted to tell. If he had, the conversation might have gone more like this:

Pt: Hello, Dr. X. I'm George Washington.
Dr: Hello, Mr. Washington. What brings you in to see us today?
Pt: I've got trouble with my legs, down by my knees.
Dr: I see. Tell me the whole story.
Pt: Oh, OK. I guess it started about 2 weeks ago when I got home from our trip to Belgium. My right leg started to hurt and then it swelled up. It's still swollen but a little bit better, I think.
Dr: I see. Pain and swelling. Anything else happen?
Pt: Well, yeah. My chest. I'm sort of short of breath and it's been hurting when I cough or take a deep breath, over here on the left where my heart is. So I've been a little bit worried about my heart.
Dr: So leg trouble, chest pain with breathing and coughing, and some shortness of breath. Anything else?
Pt: No, that's really it. Except my dad had a heart attack when he was about my age now. So it's got me worried.
Dr: Right! Worried about your heart. I can understand how that would be.
Pt: That's it, Doc. I think you've got it all.

The Techniques

Textbooks containing guidance on how to conduct a medical interview recommend open-ended inquiry, defining that skill mostly as a matter of avoiding closed-ended questions, such as "Are other joints bothering you?" [5–8]. We have found that an easier directive is to emphasize 3 specific interview techniques: inviting, listening, and summarizing ("ILS"). At the University of Colorado, students have been taught this technique over the past 5 years as part of the communication curriculum. The students find that they can understand and master the 3 techniques quickly [9].

Invitations lead to a story instead of an answer. They ask the patient to "tell about" something. Key invitations in the second interview included, "What brings you in to see us today?," "Tell me the whole story," "Anything else happen?," and "Anything else?" The first interview included one open-ended invitation, "What brings you in to see us today?" Most physicians include one such open invitation in their interview but then switch to narrow questioning. We suggest continuing with invitations until they cease to produce usable data before switching to more specific questioning.

Listening is a complex activity. It includes nonverbal behavior, such as sitting at the same level as the patient, looking at the patient, nods, and monosyllabic evidence of attending (eg, "I see" and "Hmm"). Perhaps the most important listening behavior is simply *not talking*. Talking interrupts listening. Equally disruptive to effective listening is the common practice of spending our listening time thinking about what we are going to say when the patient stops talking. Students have told us that using a short list of generic invitations ("What else?," "Tell me more," "Go on") allows them to stop worrying about their next specific question and attend more to what the patient actually says.

Finally, **summaries** help assure that we get the story right and that the patient feels heard and understood. In the second dialogue, the physician's summaries included "Pain and swelling," "So leg trouble, chest pain with breathing and coughing, and some shortness of breath," and "Worried about your heart." These summaries serve several functions: The patient's story is correctly heard; the patient feels heard and understood; the summaries serve as platforms from which to launch the next invitation; and, when the summary is of an idea or value or feeling, it fulfills the role of empathic communication. Summaries also help the physician and the patient to organize complex information into a shared narrative [10,11]. This collaborative process brings together the patient's experience (often confusing and scary) with the physician's expertise.

Is ILS enough? Can we do away with all our "doctor questions?" Probably not. At some point, the patient will have finished his story, been heard and understood, and the doctor will still have some clarification questions to ask. Some sort of bridge between the 2 activities will help:

Dr: Mr. Washington, let me shift gears here for a bit and ask you a few doctor questions. I want to clarify a couple of the things you said and ask about a few other items.
Pt: OK.
Dr: Well, I'll list a few symptoms. Tell me if you have any of these. Coughing up any nasty stuff? Any blood? Having any fever? Chills?
Pt: No, none of that.

Dr: OK, any injury? Any blow to the chest or injury to your leg?
Pt: No. But you know, you asked if I had coughed up any blood …
Dr: Yeah?
Pt: Well, a couple of days ago there was a little sort of brown stuff in my morning cough. Just a bit.
Dr: I see. Anything else you remember about it?
Pt: No, that's all, Doc. Just a little bit of brown stuff.

In fact, if the patient answers positively to any of these narrow questions, it is time for the doctor to resume ILS. One weaves back and forth between the 2 approaches, with positive responses leading to inviting the story again.

Obstacles

Teaching this triad of techniques has been successful with the majority of students. A few find the triad difficult to master, often objecting to the requirement for summaries and noting that they are "unnatural" and do not occur in ordinary conversation. We agree with their observation. However, the medical conversation differs from casual conversation in at least 3 ways that support the need for summaries.

First, medical conversations are often between 2 persons who do not have a significant past history of communicating together. They are strangers. Often they may not have shared experiences or shared ways of describing events and symptoms. Most students' casual conversations are with their peers and occur in a shorthand: "Hey, how about Chinese tonight?" The response might be "OK." One does not usually respond with a summary: "So, what you are saying is that you are hungry and would like to eat Chinese food tonight, is that right?" On the other hand, a medical interview between a student and a patient with a drug addiction might have this exchange: "You know, I've lost everything I've really cared about—my job, my girlfriend, my savings, my self-respect. Everything." In this case, an "OK" would sound inappropriate and callous. A more fitting response might be, "Sounds like you've lost a lot." Such a summary confirms understanding and has the added simultaneous benefit of showing empathy.

Second, medical conversations contain critical data. Like the conversations between airline pilots and air traffic controllers, medical conversations should be "gotten right." Errors of understanding of the data are dangerous to the patient and should be avoided [12].

Third, medical conversations often carry highly emotional content: fear, sadness, and anger. If those affects are not clearly recognized or the recognition isn't voiced, the patient will feel worse, not better, after the conversation. Empathic communication is not a luxury; it is an essential.

Students and other neophytes at these techniques often believe that patients will rebel against summary statements, thinking them mere parroting or condescending. We rarely see such resistance from patients, who are usually pleased that they are being heard and understood and find the summaries comforting and clarifying.

How Much Is Enough?

Students also often ask, "How much is enough?" How many invitations, how many summaries, how much uninterrupted listening? We suggest that the student listen uninterruptedly to the patient's initial narrative for at least a full minute. Studies have shown that patients uninterrupted by physicians' questions talk for a minute or 2 and then run down. As to invitations, because most medical conversations contain a single invitation (the initial one), one might improve matters greatly by adding 1 or 2 others. We think that a 10-minute interview usually can contain 6 to 12 invitations. Then nearly the same number of summaries seem appropriate. In practice, we often encourage the student to aim for 10 or 12 summary statements during a 10-minute interview in order to fully practice the technique. Do these summaries merely simulate sincerity and empathy? We think not. We note that practicing empathic behavior with open-ended invitations and summaries eventually leads to real understanding and real empathy [13].

Summary

We have found that the usual mode of physician inquiry is inefficient, ineffective, and alienating for patients. A better approach is the use of ILS, a 3-part interview sequence: Invitation to tell a story, uninterrupted Listening, and Summaries of what has been heard. This approach leads to improved data gathering, better physician-patient rapport, and a better platform for forward-moving steps, such as patient education and enlistment.

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