# "Tell Me about Yourself": The Patient-Centered Interview

*The following article initiates a series on "Words That Make a Difference." Developed under the sponsorship of the American Academy on Physician and Patient, the series will focus on the language physicians use when they talk with patients. Although clinicians understand how important it is to communicate effectively with patients, they often have difficulty knowing exactly what the "best words" are for making the most of each patient interaction. Drawing on careful observation and research results, the authors of this series of articles have identified words and expressions that have proven particularly powerful as tools for understanding patients and helping them manage their illnesses effectively. We are interested in knowing what readers think of the series, and in learning about other uses of language that readers have found important and helpful.*

*The Editors*

Patient: That specialist you sent me to is probably a pretty good doctor, but you can't talk to him.

Physician: What do you mean?

Patient: Well, he just didn't seem interested in what I had to tell him. He might know about kidneys but he didn't want to know what I was worried about.

This disgruntled patient is not the first to wish that his physician would focus more attention on his concerns, feelings, and ideas. Many patients complain similarly, identifying a critical weakness in the medical interview and subsequent treatment. Unfortunately, patients may feel this way even about physicians who are highly experienced and very skilled technically. Inattention to the person of the patient, to the patient's characteristics and concerns, leads to inadequate clinical data-gathering, nonadherence, and poor outcomes (1–14). Because each patient's experience of illness is unique, the best patient care includes attention to the patient's motivation, values, and desires; to her thoughts and feelings; and to the way she experiences her illness. Growing evidence suggests that physicians who focus on the patient as well as the disease obtain more accurate and thorough historical data, increase patient adherence and satisfaction, and set the stage for more effective patient–physician relationships (15–32). Although concerns are often raised that practice conditions may not allow clinicians the time to give attention to these issues, clear evidence indicates that interviews that attend to patients' feelings, ideas, and values actually save time (33, 34). Physicians can refine their existing skills in ways that allow them to attend better to the person of the patient as well as the patient's disease. The resultant patient-centered interview increases both patient and physician satisfaction.

Recommendations to focus on the person of the patient are not new. Osler (35) urged that physicians "care more particularly for the individual patient than for the special features of the disease," and Smyth (36) provided this suggestion for effective doctoring: "To know what kind of person has a disease is as essential as to know what kind of a disease a person has." Despite knowing this, physicians find it difficult to go beyond disease-centered clinical encounters. Current social and economic constraints on practice, along with medical training that does not equip physicians to deal with the patient's expression of values, ideas, or feelings, lead to clinical interviews that focus on understanding only the patient's disease. Even well-motivated clinicians may find that they are uncomfortable with and untrained to respond to the person of their patient. The spoken language is the most important diagnostic and therapeutic tool in medicine, but physicians-in-training as well as experienced clinicians report that even when they wish to focus on the patient, they lack the words to do so. Because they "do not know what to say," they avoid the challenge (37).

Developing a repertoire of carefully refined words is useful, and such mastery of language plays a recognized role in educating physicians to interview patients. Clinicians all learn, for example, to define a patient's physical pain with questions such as "Where does it hurt?", "Where else?", and "Have you noticed anything that seems to increase the pain?" In this article, we suggest language for conducting a patient-centered interview, offering words and phrases to help the physician who desires a more effective relationship with patients and who wants to communicate that patients are understood and valued. Of course, not all the questions cited should be used in any one interview. Often one request to the

 

patient—"Tell me about yourself"—will suffice. No one phrase works equally well for all physicians or all patients, and a skilled interviewer will titrate the language to the patient and the circumstances. A reader who wants to try these questions and directions might best choose a few favorite lines and try them out in clinical encounters.

## WHAT DO PHYSICIANS NEED TO KNOW ABOUT THE PERSON OF A PATIENT?

In getting to know the person of a patient, there are five main areas of concern:

1. Who is this patient? What constitutes that person's life? What are the patient's interests, work, important relationships, major concerns?

2. What does this patient want from the physician? What are his values and fears? What does he hope to accomplish here today or in the long run?

3. How does this patient experience this illness? Specifically, what has it done to her functionally; how has it affected relationships; and what symbolic meaning does it hold for her?

4. What are the patient's ideas about the illness? What is his understanding and perception of the disorder and its cause? What would seem to him to be reasonable treatment for it?

5. What are the patient's main feelings about the illness, with special attention to the five common responses: fear, distrust, anger, sadness, and ambivalence?

Physicians may touch on these areas of concern in routine medical encounters but seldom explore them fully. To do so lays the groundwork for a relationship based on understanding and trust, a mutual dedication to the patient's health that is truly therapeutic.

## HOW TO SAY IT

### 1. Who Is This Patient?

According to Stoeckle (38), "Patients bring not only their bodily complaints but also the circumstances of their everyday lives—who they are and might hope to be . . . Elicitation of this psychosocial information about the patient is useful for relationship building, diagnosis, and the tasks of management."

Some clinicians like to begin an interview with a new patient by asking about the person himself: *Before we get to the medical problems, I'd like you to tell me a little about yourself as a person.* Those who prefer to get right down to the biomedical facts can make room for such an inquiry later: *Now that I've heard a little about this illness, and before we go on to review all your other health issues, I'd like to learn about you as a person.* In either case, most patients will provide a capsule summary, seldom longer than 30 seconds, of their lives and interests. Occasionally a patient will hesitate and ask, "Like what?" If so, the physician can reply, *Well, your work, who's at home, what goes on in your life—that sort of thing.* Sometimes the most open inquiry works best: *Tell me about yourself. How would you describe yourself? If you had to describe yourself in 50 words or less, what would you say? What if you wanted to expand on that?* Once the reluctant patient responds, the interviewer can ask for more details: *Tell me about that.*

Sometimes the physician may offer to trade information: *We should take a little time to get to know each other since we will be working together now. Let's start by my asking you to tell me about yourself, and later I'll be glad to answer your questions about me.* Sometimes, of course, the physician is the new kid on the block: *You've been coming here a long time, but I'm new. Tell me a bit about yourself.*

With returning patients, one can ask for interim reports: *What's new in your life lately? Any changes in your life since your last visit here?* Or, if the physician knows about a big event in the patient's life: *How did that trip to Chicago go?*

### 2. What Does This Patient Want from the Physician and the Medical Team?

Physicians often assume that their patients' goals are exactly the same as the clinician's. But especially at the beginning of a relationship, it pays to inquire more fully: *Since we're new to each other, it would help me to understand what you're most hoping for in a relationship with a new doctor.* Sometimes the patient has left a previous physician because of some dissatisfaction, perhaps a communication problem: *Since you told me that you left Dr. X because the two of you weren't communicating very well, can you tell me what works best for you in communicating with a doctor? What can we do to avoid having another communication problem like the one you experienced with Dr. X?* Or, in the currently more common scenario of change: *I can imagine that it is a real loss for*

*you to have to leave Dr. Y just because your insurance changed. Can you tell me what worked well for you in your relationship with Dr. Y?*

Parenthetically, one should note that a question such as *Can you tell me . . .* is theoretically answerable with a "yes" or a "no" and thus appears to be a closed-ended query, the sort physicians are urged to avoid. But most patients would take this question to be an invitation to tell more and would respond with an appropriate story, not a one-word answer.

Sometimes physicians will discover that patient expectations contrast strongly with the physicians' own view of the patient's role and possibilities. Physicians may have to uncover that difference in their conversation with the patient: *I see. It sounds as if what you expect from me is A, B, and C. But the difficulty I'm having is that the way I see my role is to do D, E, and maybe F. So we have different ideas about what I can do for you. How can we best proceed? Do you see any place where we can get together here?* Unexpressed and ultimately conflicting expectations have torpedoed many a promising medical relationship, so it's best to uncover them early.

An inquiry into the person of the patient segues naturally into asking about symptoms: *What sort of troubles are bothering you? What else? Tell me more about X, Y, and Z.* But even here one is still interested in the patient's expectations, hopes, and why he or she consulted the physician now: *What led you to come in today, instead of a few weeks ago or maybe a few weeks later? What were you most hoping to accomplish here today? It sounds like the two key issues are A and B. How can I help with these in particular?* (39, 40).

### 3. How Does This Patient Experience This Illness?

Kleinman (41) noted that "one unintended outcome of the modern transformation of the medical care system is that it does about everything to drive the practitioner's attention away from the experience of illness." To Kleinman, "illness refers to how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability," as opposed to disease, a construct that focuses on cause and mechanisms. When physicians ask about the patient's experience of his or her illness, the more open the inquiry can be, the better: *What has this illness been like for you? I can imagine that this illness has been pretty disruptive of your life. Can you tell me about that?* Or, *From what you say, I imagine that this illness is very hard for you. Can you tell me what it's been like for you?* Forsaking questions for simpler directions, nothing beats *Tell me more about it* (42–45).

If an interviewer wants to help her patient with more specific questions later on, she can ask about how the illness affects 1) his functioning: *Since you've had this problem, what are you no longer able to do or have trouble doing that you used to be able to do?*; 2) his relationships: *How's your family handling this?*; and 3) his self-image: *Do you think of yourself differently in any way since this problem appeared?*

### 4. What Are the Patient's Ideas about the Illness?

Every sick person who goes to a healer has probably devised an explanatory model that describes what is wrong, how it came to happen, and what ought to be done about it. Physicians need to learn about patients' explanatory models, perhaps even noting these valuable data in the chart as "EM." They can ask about etiology theories: *What do you think is causing these headaches? What ideas do you have about why you might be having them? Why do you think this is happening right now?* About thoughts on prognosis: *What are your concerns about this? When you think about what might happen to you because of this, what is most worrisome?* And about appropriate therapy: *What had you thought we ought to do about this?* Then, for patients who hesitate to voice their explanatory model or even deny having one—for example, "I haven't a clue. That's why I came to you"—the physician can respond, *I understand. But you've probably had some thoughts on the matter.* Or even, *Well, if you DID have a theory, what would it be?* Less colloquial phrasing might be, *Well, I may have some ideas, but it is really important for me to understand as well as I can what you think about what is wrong with you. Then we can discuss our ideas together* (46, 47).

What if the patient's diagnosis or ideas about treatment differ widely from the clinician's? Physicians can bring the difference to the surface and show that they are prepared to listen further: *Sounds like you've been thinking the problem is Y and that we ought to do Z for it. From my perspective it looks more like R or S. What do you think?* (48–57).

### 5. What Are the Patient's Main Feelings about the Illness?

Not only are many physicians hesitant to ask about feelings, their patients are often hesitant or simply unable to express feelings to them (58). They may offer hints that the physician can follow up: "You know, when you find a lump in your breast? You feel, kinda, well, you know." Physicians may need to use both direct and indirect techniques to discover patients' emotions. They can ask directly: *How does that make you feel? What's the feeling that goes with that? You know, the emotions?* Sometimes asking about emotions yields an answer that is not an emotion but rather a generic theory of how people might be constructed or act:

Physician: How did it feel to have this injury just when you were going to do the New York Marathon?

Patient: Well, you have to understand how your muscles work and that they can get strained.

The physician may have to reiterate that feelings are important. For example, *I'm interested in knowing why you think it happened, but I also want to know what your personal reaction was; you know, the emotions that you experienced when your Achilles tendon snapped.* When direct questions still elicit no emotion or when the patient says he or she has none, the next step is to prime the pump by self-disclosure or suggestions of possible impact on the patient's life or the lives of others: *If I were working toward something like running a marathon and then at the last minute I couldn't do it, I know that I'd feel angry (or frustrated or depressed).*

As a general rule, it is important to persist gently in asking the patient about emotions because many patients are not used to expressing their feelings to anyone, even to a physician. If the patient remains reticent and perhaps even expresses his or her difficulty—by saying, for example, "I don't like all these questions about my feelings"—the physician can respond as he does when any of his inquiries touches a sensitive topic: *I see that you don't want to talk about this. Of course, you don't have to tell me anything that is too uncomfortable to talk about. But as a doctor I have to try to understand as fully and as precisely as I can, so I sometimes ask questions that seem intrusive. The better I can understand you, the more helpful I can be to you.*

Once the physician has uncovered a powerful feeling, he may wonder what to do next. His first task is to communicate his understanding clearly to the patient: *I see. So this experience with the breast cancer has been pretty frightening both to you and to your husband. I can understand how that would be.* Once he has communicated that understanding and the patient has acknowledged it, the physician's next action is often no action at all. Clinicians often fear "opening Pandora's box" and discovering powerful feelings that they don't know what to do about. In fact, the physician can simply remain silent, present, and attentive while reflecting on his understanding and allowing the patient to absorb the sense of being understood.

## RESPECTFUL ATTENTION

Along with the words that encourage a patient to share hopes and concerns, respectful attention is a way of building a long-lasting therapeutic relationship. A physician's nonverbal communication of attitude and feelings speaks as loud as what she says, and undivided attention is the strongest evidence of a desire to help the patient. Leaning slightly toward the patient, nodding, making eye contact, and using facilitative hums and murmurs all show interest. Interviewers should not allow the pace of questions to interfere with close listening. Similarly, observing common culturally appropriate courtesies, such as using patients' names in the way the patients choose to have them used, shaking their hands, and showing concern for their comfort and privacy, demonstrates the physician's respect. To be truly patient centered, physicians must demonstrate both verbally and nonverbally that the most important part of the medical interview is the person facing them (59–61).

## DISCUSSION

Studies that demonstrate poor patient adherence make it clear that patients frequently disagree with physicians' diagnoses and treatment plans; this leads to unfilled prescriptions, partially used medications, lack of follow-up with referrals and return visits, and poor outcomes (1, 5, 6, 61–65). Understanding how the patient views his or her illness and the physician's role in treating it will help increase adherence and the physician's effectiveness. Investigators of clinical decision making come to the same conclusions about the need to investigate patients' ideas, as do those who study and use patient-centered techniques (49, 50).

These techniques and the supportive language are not instinctive. They may indeed feel awkward at first.

Initially, some physicians may see a patient-centered approach as impractical, claiming that there is insufficient time to learn more about the person of the patient. However, a skilled physician can obtain a useful sketch of the patient as a person in less than a minute. The picture then becomes richer and more complex as the relationship develops. In fact, studies show that contrary to intuition, permitting patients to state all of their concerns without interruption does not add substantially to the length of the interview (5–9, 33, 34).

Another common belief is that patients expect a more disease-centered or physician-oriented approach. If physicians focus too much on personhood, especially early in the relationship, the argument goes, patients who expect a disease-focused interview might think that the physician is minimizing the seriousness of their physical symptoms or ascribing them to psychological causes. However, patient surveys and lay literature make it clear that many patients are dissatisfied with the status quo and would prefer that their physicians listen better and interact more with them as persons (66–78).

A final concern is that patient centering might risk getting too close to the patient, thereby compromising objectivity and professionalism. For example, encouraging patients to express their emotions or sharing one's own feelings or values with patients might impair clinical detachment. This belief is based on the mistaken premise that good clinical decision making requires the physician to be unemotional and distant. On the contrary, for physicians to be therapeutic, they must connect with their patients on at least some emotional level to motivate them toward healing (79).

To center the medical interview on the patient as well as the disease, the physician must offer both nonverbal and verbal evidence that what the patient has to say is important. Careful listening and considerate treatment can be paired with inquiries about the patient's current status, experience of the illness, and expectations of the physician to build a therapeutic bond. In the end, the two most useful physician qualities may be curiosity and patience—curiosity to ask questions such as "Tell me about yourself," and patience to wait for the answer.

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