FOR CUBAN DOCTORS TO WORK ABROAD: DOCTOR-PATIENT MEDICAL INTERVIEW HINTS

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ABSTRACT

The clinical method or the evidence-based medicine has become a very important factor that has made medicine a more humanistic specialty. The sophisticated scientific discoveries and dramatic technological innovations of the past few decades have substantially altered the manner in which diseases are diagnosed and managed. In this era of technological, state-of-the-art, "modern" medicine, however, one of the primary principles of compassionate care – listening to the patient – is often overshadowed by the results of imaging studies and laboratory tests. Productivity demand shorter hospitalizations with more frequent physician team handoffs, among other factors, provide challenges and barriers to making a connection with patients. The importance of physician communication skills within the paradigm of the physician–patient relationship is not a new concept. Sir William Osler once remarked, "The good physician treats the disease; the great physician treats the patient who has the disease". The emerging body of literature on quality and safety in medical care has demonstrated an unequivocal benefit of good communication on improved outcomes and clear associations of communication deficiencies with medical error and negative patient experiences. Therefore, effective communication in medicine is of paramount importance for care providers and patients. This review focuses on the development of effective communication strategies and patient-centered interviewing techniques that may facilitate successful physician–patient relationships and improve medical care provided by any medical specialist.

Keywords: medical interview, evidence-based medicine, communication strategies

INTRODUCTION

In the 1960s, Engle developed the concept of the "biopsychosocial model" of patient care to incorporate the broader psychological and social context of the patient into an understanding of their overall health. Since that time, numerous partnership models for physician–patient communication have been developed. The Institute of Medicine popularized the concept of "patient-centered care". In educational materials, the American College of Obstetricians and Gynecologists endorse the GATHER and RESPECT models for improved communication. While the acronyms, wording, and phrasing may differ slightly between organizations and models, a unified concept has emerged: namely, that quality medical care requires a combination of comprehensive scientific knowledge and sophisticated communication skills.

The medical interview is the practicing physician's most versatile diagnostic and therapeutic tool. However, interviewing is also one of the most difficult clinical skills to master. The demands made on the physician are both intellectual and emotional. The analytical skills of diagnostic reasoning must be balanced with the interpersonal skills needed to establish rapport with the patient and facilitate communication.

Interviewing is often considered part of the "art" in contrast to the "science" of medicine. There are many reasons to dispute this distinction. Perhaps the most compelling is that labeling it an "art" removes interviewing from the realm of critical appraisal and suggests that there is something magical or mysterious about interviewing that cannot be described or taught. This paper will try to demonstrate the validity of interviewing as a clinical science based on critical observation and analysis of the patient without diminishing its excitement as a clinical activity. It provides a guide to conducting initial interviews and making sense of what happens. It will outline the knowledge, attitudes, and skills that lead to effective interviewing. It will also focus on the problem-oriented

diagnostic interview, but the health promotion interview and interviews during follow-up visits will also be mentioned.

Interviewing is a practical skill that can only be learned through doing. No amount of reading can replace the experience of actually talking with patients, especially if the student's interviews can be observed and critiqued. The clinicians should in fact spend a great deal of their time talking with patients.

The medical interview provides two categories of information unavailable from any other source: *what* the patient says about the illness and *how* it is said. What the patient tells the physician provides the factual *content* of the medical history. The factual content is what the physician edits and records in the written record—the medical history. It should include a comprehensive, chronological report of the patient's illness with enough information, both positive and negative, for accurate and inclusive diagnostic reasoning regarding possible etiologies of the patient's problem(s). The *process* of the interview is what actually happens between physician and patient during their encounter.

Observation of process, both verbal and nonverbal, provides important information about the patient as a person. Through the patient's behavior during the interview (e.g., facial expressions, posture, gestures) he or she communicates emotional concerns, reactions to illness, and style of relating to others. Sudden shifts of topic, avoidance of certain issues, and the flow of spontaneous associations may point to concerns that are not expressed directly. The physician's communication style and behavior during the interview is also a critical element of the interviewing process.

The distinction between content and process highlights the dual skills required in the medical interview—analytical and interpersonal. Although these skills can be discussed separately, they must be practiced together. The clarity and validity of information gathered during the interview (its content) may be critically determined by the quality of the relationship that develops between patient and physician (its process). A candid disclosure of patient concerns is most likely to come about in the context of a nonjudgmental interviewing style.

A final comment on process and content may be helpful to the beginning student. The content and organization of the written medical history is often confused with the process by which the clinician actually collects information during the interview. The written medical history is actually a journalistic endeavor in which the clinician edits and organizes the patient's spontaneous report into a formal, organized presentation. The final product in the medical chart may bear little resemblance to the work the clinician performs at the bedside. Patients rarely report their symptoms in an organized and logical fashion comparable to the descriptions of disease in medical texts. In fact, patients complain of illness or sickness rather than stating their problems in terms of the pathophysiologic categories of disease. Students who expect their patient's to present classic symptom complexes in an organized fashion experience considerable frustration and may become rapidly disillusioned with clinical medicine. The complaint that "The patient was a poor historian" may reflect unrealistic expectations on the interviewer's part.

In clinical practice, the interview is a collaborative effort between physician and patient Reiser (1980)_states that, "The physician, no matter how skilled, cannot simply extract a history from his patient. The patient, no matter how articulate, cannot give a history in final form without help and guidance from the physician." To say that we "take a history" from the patient implies that the story of illness can be extracted from the patient, like shaking a coin from a piggy bank. This erroneous conception of the medical interview leads to frustrated attempts at shaking out the history as if the patient was willfully keeping this valuable coin hidden.

The first minutes give the observant physician valuable information about the patient's communication style and behavior, as well as providing a tentative list of problems. Some patients need considerable prompting to discuss their current problems, while others need limits set because of a rambling history. The patient's vocabulary and clarity of expression can be assessed early in the encounter. Emotional reactions such as anxiety, defensiveness, or hostility are often evident. All these elements are important in determining the patient's reliability as a historian. The first minutes give the interviewed time to "calibrate" his/her techniques to the individual patient (Engel). By recognizing the patient's emotions and responding to them in a supportive manner, the clinician can conduct an effective patient-centered interview. As examples, the interviewer will

expect the confused patient to give a confused history; the emotionally reactive patient to embellish and exaggerate symptoms or reactions; and the depressed patient to be withdrawn and require considerable support.

The interview to the patient can be thought of as having two parts: (i) the setting for the interview and (ii) the interview process itself.

The Setting:

The setting is important because it creates the environment in which the doctor and the patient must interact. The environment will greatly influence how comfortable the patient feels during the process and how complete and informative the patient's answers will be. It is normal to expect patients to experience some degree of anxiety during an initial interview, if for no other reason than they are about to discuss personal matters with a stranger. If your approach is more like an interrogation, the patient will be closed and unresponsive to your questions. If your tone is judgmental, there is a chance that the patient will disregard you advice and instructions. In either case, the patient is very likely to seek another doctor. Patients want to feel comfortable and at ease when talking to their health care provider. And they have a right to expect a pleasant and professional approach to their problems. If it is the first patient of the day this is easy, on the other hand, if it is the last patient after a horrible day, it may be easier said than done. Within limits you may be able to adjust your physical surrounding to facilitate good interviews. Try to avoid having a table or counter between you and the patient. A cold, sterile room is not conducive to discussing hemorrhoids, while a carnival-like atmosphere may not inspire the level of confidence you are seeking. Check your seating position – make sure your seating is no higher than eye level. Patients are very uncomfortable having to look up while talking and are actually most comfortable while looking slightly down. Be aware of your body language – avoid body positions that are defensive or withdrawn. Be aware of eye contact, too much and too little are both bad. Watch your vocabulary – don't overwhelm the patient with highly technical terminology they don't understand; at the same time, don't talk down to the patient. Lastly, a warm hand shake is a very comforting gesture towards a new patient and it's also a nice way to conclude the visit.

The Process:

The questions are the key to a good interview. You need to use a mix of "open ended questions" and "close-ended questions." Open ended questions leave the do or open for the patient to tell you more. Questions like "when it this problem start?," "have you had any recent health problems?," and "can you show me where it hurts?" are open ended. The patient feels free to provide additional information. While questions like "does it hurt here?," "did you have this pain yesterday?, " and "have you had the flu in the past month?" are close ended. Close ended questions seek very specific, often yes or no responses from the patient and don't encourage the patient to provide any additional information. Good interviews are a mixture of both kinds of questions.

Table 1. The five step model

Steps	Description	Actions to facilitate patient-centered interaction
1	Set the stage for the interview	• Welcome patient, use patient's name, clinician introduction of him/herself • Ensure patient´s readiness and privacy • Remove communication barriers • Establish patient´s comfort
2	Elicit the chief complaint and set an agenda for the visit	• Indicate available time • Obtain list of issues patient wants to discuss • Summarize/finalize agenda, prioritize items for current encounter vs future encounter
3	Open the history of present illness (non-focused)	• Ask open-ended questions to elicit problems • Use active listening, which includes silence and non-verbal encouragement
4	Continued the patient-centered history of present illness (focused)	• Use focused, but open-ended, questions to obtain description of physical symptoms • Explore patient´s description of symptoms, emotional or social context of symptoms
5	Transition to the clinician-centered process	• Summarize conversation, confirm accuracy of information • Inform patient that style of questioning will now change ("I'm now going to ask you several specific medical questions about your symptoms")

Data from Smith RC. Patient-centered interviewing: an evidence-based method, 2nd ed. Philadelphia (PA): Lippincott Williams & Wilkins; 2002.

Table adapted from Committee Opinion #492, Effective Patient-Physician Communication, American College of Obstetricians and Gynecologists, May 2011.

Good mnemonic systems help doctors to avoid missing important patient assessment steps and questions. The **SAMPLE** interview mnemonic is a reasonably helpful mnemonic system for obtaining important patient information:

Signs/**S**ymptoms reported by the patient. **A**llergies **M**edications **P**ast Medical History **L**ast Oral Intake **E**vents leading to this episode of injury or illness.

All of the above information is vital to assessing and treating any patient. But, obtaining a complete and accurate **SAMPLE** history requires very specific questioning techniques.

Unfortunately, no core curriculum texts (and very few instructors) adequately train Prehospital or Inhospital emergency medical personnel precisely ***how*** to Interview people!

"GOLDEN RULE #1" OF INTERVIEWING PATIENTS: Avoid "closed-ended-questions" when interviewing patients about anything!

A "closed-ended-question" is one that can be answered with a "yes" or a "no." **"Are you having difficulty breathing?"** is a closed-ended-question.

"How's your breathing?" or **"How does your chest feel?"** are "open-ended-questions."

Open-ended-questions require the patient to actually ***describe*** his complaints. Thus, open-ended-questions yield much more accurate, much more patient-specific, information than closed-ended-questions. Additionally, open-ended-questions yield this better information much ***faster*** than closed-ended-questions.

"GOLDEN RULE #2" OF INTERVIEWING PATIENTS: Use the patient's words, and only the patient's words, when referring to - or reporting - his complaints.

Once a patient offers you descriptive information, use ***only*** the ***patient's terminology*** when referring to his complaints, or when reporting his complaints to others. Never, ever, put ***your words*** in place of the patient's words.

If a patient says, **"My chest feels really tight!"** do not later refer to his complaint as chest **"pain."** He didn't complain of chest **"pain."** He complained of chest **"tightness."**

When you use words the patient didn't use to refer to his problem or describe it to others, you are sending the patient the message, **"I'm not listening to you!"** Patients do not respond well to providers who aren't listening to them - consciously or unconsciously.

Another danger of using ***your words*** to describe the patient's complaint - another danger of using open-ended-questions- you can "lead" the patient to complain of things that he isn't actually experiencing.

"Are you short of breath?"... "Well, now that you mention it ... yeah!" vs. **"How's your breathing?"... "My breathing's fine! It's this tightness that's bothering me!"**

Leading the patient to complain about things he's not experiencing can lead to misdiagnosis and inappropriate or delayed treatment.

"Labeling" patients is a bad habit. But, in an effort to be faster, ***all*** care providers do it. I'm not going to fight that battle. But, whatever you do, never, ever "label" a patient using any term that the patient hasn't used! Not only can that lead the patient to complain of something he's not experiencing, it can misrepresent the patient's complaints. Misrepresenting the patient's complaints can lead to misdiagnosis and inappropriate or delayed treatment.

"GOLDEN RULE #3" OF INTERVIEWING PATIENTS: Denial = Positive Confirmation. If a patient denies complaints involving a specific area/function, require him to confirm that there is nothing wrong with that area/function.

"How's your breathing?" "It's fine. I told you, it's my chest that hurts, dammit!" "So, your breathing feels *completely normal?*"

You're absolutely right! That's a "close-ended-question. But, it's a quick way of getting the patient to either confirm his denial of a complaint, or to explain why he didn't mean to "deny" a complaint. Often, patients don't consider complaints other than their primary complaint as being "important" enough to tell you about. Or, they worry that they'll distract you from fixing their primary complaint if they "fuss" with telling you about other signs and symptoms.

Notice that, although I used a closed-ended-question, I didn't use one that ***suggested*** a complaint! (Such as **"So, you're not short of breath?"**) Suggesting complaints leads patients to complain of something they're not experiencing. Whereas, suggesting the ***absence of complaint*** requires the patient to "argue" with you if they are experiencing a complaint. Then, you can require them to better describe their complaint.

"How's your breathing?" "It's fine. I told you, it's my chest that hurts, dammit!" "So, your breathing feels completely normal?" "Well, no ... sometimes I get a little short of breath." "When do you get a little short of breath?" "Well, when my chest gets tighter." "When does your chest get tighter?" "When I have to do something ... you know ... like go up or down stairs... or lift something. But, it's my chest that hurts, dammit!"

SIGNS/SYMPTOMS REPORTED BY THE PATIENT ="What's wrong?"

<u>"S" PART ONE:</u>

You quickly want to determine ***what*** complaints (signs/symptoms) this particular patient has, and what do the complaints feel like - using open-ended-questions.

"What's wrong?"... "What's bothering you?" Notice that the suggestion is not to ask, **"What made you call us today?"** or **"Why did you call us?"** Those kinds of questions, even when "sweetly" intoned, are antagonistic.

"What's wrong?"... "What can I do for you today?"... "How can I help you today?" If a patient says, **"My chest hurts!"** ask him/ her, **"How does it hurt?"** or cue him/ her to, **"Describe what it**

feels like." Avoid asking closed-ended-questions such as, **"Is it a squeezing pain?"... "Is it a stabbing pain?"** Again, once you start asking closed-ended questions, you'll have to pedantically offer a multitude of pain-quality-terms just to determine what the patient's chest feels like. And, if you never offer a term that the patient considers appropriate, you'll either never know what the patient's complaint feels like - ***OR***, the patient will "settle" for one of your words (even though it's not quite "right") just to get you to shut up!

Get all the information you possibly can about the ***first complaint*** that the patient describes before you go on to any other complaint. If you don't, you'll get distracted, and gather only incomplete information.

If you ask, **"What's wrong?"** and the patient replies, **"Oh! My chest is tight, and my head aches, and I can't catch my breath!"**: stay with the first complaint until you've got all the information you need about it. **"Tell me about this chest tightness. When did it start bothering you?"** Once you've got all the information about the chest tightness, then ask about the next complaint the patient listed. **"Tell me about your head aching."**

"S" PART TWO: "What else is bothering you?" If you don't ask the patient to describe his ***other*** complaints, you may not learn about them at all. Patients are often so completely preoccupied with their primary complaint, that they're relatively unaware of other complaints. (This phenomenon is likely the genesis of the, **"He didn't tell ME that!"** aggravations frequently experienced after turning patients over to other care-providers.) Even when the patient's primary complaint doesn't represent his most life-threatening problem, it's what's bothering him the most. So, he won't tell you about anything else until you've "fixed" what's bothering him the most! OR - until you firmly require him to tell you about his other complaints.
Require every patient to fully describe ***each*** complaint or altered-condition that he's experiencing - in his own words. **"What else is bothering you?"** Keep asking **"What else?"... "What else?"... "What else?!"** until the patient insists that(s) he's described ***all*** of his complaints for you.

"RADIATING PAIN" or "RADIATING COMPLAINTS": "Does your chest discomfort *go* anywhere?"
"No! It's right *here!*" Guess what? Ask that ***same*** patient, **"What else is bothering you?" "Well, my left shoulder and arm have been kind of achy the past day or so. But, it's my chest that hurts, dammit!"** Patients should **never**, ***ever*** be expected to decide what a "radiating" complaint is and what is not! They don't understand the significance of "radiating" complaints - nor do they even recognize what a "radiating" complaint is!! They don't perceive their complaints as "***going anywhere***" but where they feel them. (And, **"Does your chest discomfort *go* anywhere?"** is a closed-ended question, anyway!)

Same problem with "associated" complaints: **"Do you have any complaints *associated* with your chest discomfort?" "No! It's my chest that hurts, dammit!"** So, keep asking, **"What else is bothering you?"... "What else?"... "What else?"** And then, ***YOU*** decide what complaints the patient reports represent "radiating" or "associated" complaints!!!

"S" PART THREE: The Head-To-Toe Open-Ended-Question Survey For every patient, especially a "reluctant describer," after you've asked, **"What is bothering you today?"** and, **"What else is bothering you?"** and, **"What else?"** ... **"What else?"** - do a quick verbal survey of their body, beginning with their head and working your way to their extremities.
(If you feel ***completely confident*** that you've heard everything you need to hear about a specific body area, you can skip it - or summarize the complaints you've noted in that area, asking them to confirm or deny your understanding of their previously-reported complaints.)
"How does your head feel?"
"How does your neck feel?"
"How does your chest feel?"
"How's your breathing?"
"How does your belly feel?"
"How does your back feel?"
And so on.

Remember Golden Rule #3: Whenever the patient ***denies*** complaints in an area, require him to ***confirm the denial***:

"How does your belly feel?"
"Fine!"
"So, your belly feels absolutely normal?"
(Again, for denial-confirmation purposes, a closed-ended question works fine - as long as you're suggesting the ***absence*** of a complaint!)
Whenever the patient identifies a "minor" complaint (or denies that an area feels "completely normal"), ask him to ***expand upon his complaint***:
"So, what's not 'normal' about it?"
"Well, what do you mean by 'odd'?"
"Please describe what you mean by 'dizzy'?"
"What kind of 'achy problems'?"

ALLERGIES:
Contrary to the vast majority of core curriculum text books and care-provider-courses, do ***NOT*** ask questions such as, **"Are you allergic to any medications?** ... **Are you allergic to any foods?** ... **Other substances?"** These are all closed-ended-questions. Using them requires a longer amount of time to obtain information, and substantially increases the likelihood that you'll miss vital allergy information. Thus, these are all crappy questions. Instead, ask, **"What are you allergic to?"**
Then ask, **"What else?"** Then ask, **"What else?"** And keep on asking, **"What else?"** until your patient insists that he's told you of ***all*** his allergies.

MEDICATION QUESTIONS: Learning about the medications your patient takes is vital. Medication information can provide important clues to the patient's past medical history, direct you to explore problems that might be "side effects" from medications (such as dehydration or electrolyte problems secondary to diuretic use), and assists your evaluation of the patient's current complaint.
But pay close attention to ***how*** you ask the patient about medications. Throughout medical history, experienced care providers have been asking "crappy" medication questions - ones that routinely yield incomplete information. Incomplete information leads to medical treatment errors. And, that's a "crappy" thing, isn't it?!

One of the most common crappy medication questions is, **"Do you take medications prescribed by a doctor?"** (Even the open-ended-question-version of that question is crappy: **"What medications do you take that are prescribed by a doctor?"**) In response to such a question, patients are entirely unlikely to report the over-the-counter medications they take; such as daily aspirin (**"I saw on TV that it would decrease my risk of heart attack, so I started taking it."**), multiple non-prescription inhalers, or gallons of antacid. Medications that aren't prescribed by a doctor are just as important to a person's health and well-being, just as indicative of medical problems, and just as important to emergency medical care considerations.

Another frequently-asked crappy medication questions is, **"What medications do you take every day?"** (See? Open-ended, but still crappy.) The patient will probably tell you exactly that, and ***only*** that. If you ask that question, the patient likely will ***not*** tell you about taking an occasional nitroglycerin tablet, or getting immunosuppressant therapy **every *other*** day, or being injected with antipsychotic medications every three or four weeks. Not all medications are taken "every day." Yet, all are just as important to medical history and emergency care considerations.

There are many other similarly "crappy" medication questions. Thankfully, I'm not going to waste print exposing them. Instead, I'll simply share with you a 4-question system for determining ***almost all*** the information you really need to know about any patient's medications.
Medication Question Number One: Ask the patient, **"What medications do you take?"** That's it! **"What medications do you take?"** Then, note what medications the patient reports.
Medication Question Number Two: Ask, **"What *other* medications are you taking?"** Especially when patients take several medications, they tend to stop reciting them long before the list is completed. Or they forget to mention one or four of them. If you stop your medication-questioning after the patient has listed two or three medications, and go on to another line of questioning, your

patient is ***not*** going to correct you! You'll rarely (if ever) hear, **"Oh! Excuse me, but I haven't finished telling you about all my medications!"**
You must keep asking, **"What other medications do you take?"... "What else?"... "What else?"** until you're sure that you've obtained a complete list. (**"That's it! I swear it! Those are *all* the medications I take!"**)
Medication Question Number Three: "What medications are you supposed to be taking, but aren't?"

Or, after using the grocery store's machine to check his blood pressure for a couple weeks, and finding it identified as "normal" (both times), a patient may stop taking his antihypertensive medication. (**"Well! My blood pressure's normal now!"**)

For ***whatever reason*** they do it, patients may stop taking medications when they shouldn't. And they rarely ever tell anyone about it. When a patient isn't taking all the medications he's supposed to be taking, you need to know about! Is his emergency related to not taking his medicine?

When they list their medications for you, patients may or may not include the medications they're supposed to be taking but aren't. So, no matter what medications they've listed, it's important for you to ask, **"What medications are you supposed to be taking, but aren't?"**

You may or may not get an honest answer to that question. (No matter what reason they've used to "justify" stopping their meds, underneath it all, patients ***know*** that they shouldn't stop taking them without being told to!) But, certainly, if the patient admits to not taking ***one*** drug he's supposed to be taking, remember to ask, **"What *other* medications are you supposed to be taking, but aren't?"**

And keep asking, **"What else?"... "What else?"** ... until the patient insists that, **"That's it! Those are the *only* medications I'm supposed to be taking, but aren't!"**

Medication Question Number Four: "What medications are you taking in a way that is different from how you were told to take them?" Patients may be taking their medications, but if they're not taking them the way they're supposed to be, the medications won't have the effect the way they're supposed to. This question identifies underdoses, overdoses, and otherwise-nontherapeutic uses.

Sometimes, in order to save money, patients take only half the prescribed dose of a medication. If the prescribed dose of a medication isn't alleviating their problem, they may take extra doses. Or (for whatever reason), they'll take them at times other than when they're supposed to. (**"I take my nitroglycerin whenever I start to feel light-headed."**) You need to know about such medication-taking alterations. (Especially since the patient's physician probably has ***no idea*** that the patient has altered his medication regimen.)

"What else?"... "What else?"!!!

PAST MEDICAL HISTORY: According to core curriculum text books, the **"P"** of "SAMPLE" stands for "**P**ertinent" Past Medical History. But, who is to say what is "pertinent" and what is not? Certainly, you cannot expect the patient to decide what is "pertinent" and what is not! Additionally, core curriculum text books ***all*** suggest extremely poor methods of questioning patients regarding their **P**ast Medical History.
Rather than wasting time going through a lengthy (and probably incomplete) set of common and crappy closed-ended-questions (**"Have you been sick?"** ... **"Do you have diabetes?"... "Do you have heart disease?"** ...), simply ask the patient: **"What medical problems have you had in the past and when did you have them?"... "What else, when?"... "What else, when?"**
Also, ask **"What physical injuries have you had in the past and when did you have them?"** (Patients don't always understand the word, "trauma")... **"What else, when?"... "What else, when?"**
Then you can mentally note (later record) the patient's ***complete*** Past Medical History, and make your care-decisions accordingly.

LAST ORAL INTAKE: "What was the last thing you drank or ate, and when did you drink or eat it?"... "What else, when?"... "What else, when?"

EVENTS LEADING TO THIS EPISODE OF INJURY OR ILLNESS: "What kinds of things were going on, or what were you doing, before this happened?"... "What else, when?"... "What else, when?"...
If you suspect that it's pertinent, **"What happened that bothered you yesterday?"... "The day before?"** ... and so on.

CONCLUSIONS

Patient-centered interviewing techniques facilitate successful physician–patient relationships and improve medical care provided by any medical specialist. These techniques should be mastered by Cuban doctors who are to accomplish their mission abroad in English-speaking countries. These specialists have to follow the three golden rules of medical interviews: 1. Avoid "closed-ended-questions" when interviewing patients about anything; 2. Use the patient's words, and only the patient's words, when referring to - or reporting - his complaints; and 3. If a patient denies complaints involving a specific area/function, require him to confirm that there is nothing wrong with that area/function. Besides, the **SAMPLE** interview mnemonic is a reasonably helpful mnemonic system for obtaining important patient information, where **S** is **S**igns/**S**ymptoms reported by the patient, **A** is **A**llergies, **M** refers to **M**edications, **P** is **P**ast Medical History, **L** is **L**ast Oral Intake, and finally, **E** refers to **E**vents leading to this episode of injury or illness.

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