SMALL GROUP SESSION 4A
September 8th or September 10th

HOSPITAL INTERVIEW
(Chief Complaint and History of Present Illness)

Suggested Readings: The Medical Interview, 5th ed. Chapter 8: The Clinical Narrative (on reserve in library)

Prepare by: Wearing your white coat and name tag, and looking professional

Brief outline:
Section 1 Touch base: (15 minutes)
Section 2 Hospital interviews: (100 minutes)
Section 3 Case Presentation and discussion: (60 minutes)
Section 4 Evaluation: 5 minutes

For Next Week: Write up your patient from your hospital interview (sample write-ups are attached). Turn it in to your mentors next week.

AND: Research a learning objective based on your hospital interview. Come prepared to discuss what you learned with your group next week.

CONFIDENTIALITY REMINDER: Do not put the patient’s name on your write-up. Refer to your patient by using Mr. /Ms. /Mrs. and first initial of last name. Do not print it out in the library if at all possible – or if you must, make sure you remove all copies. People have discovered write-ups of their friends on the library printer in the past – not good. Do not discuss your patient in a public area.
Objectives for Session 4A
By the end of this session, students will be able to:
- Practice eliciting a chief complaint, and taking a history of present illness (HPI).
- Practice specific interviewing skills and observe how a patient responds to them
- Elicit how the patient is coping with illness and how the illness is affecting the patient and family
- Evaluate an interview done by a fellow student and give constructive feedback.

SECTION 1: Touch base (15 minutes)
How is medical school going?
Is it what you expected?

SECTION 2: Hospital Interviews (100 minutes)
This is your first interview with a real patient in the hospital. You will interview him or her in pairs, then return to discuss your experience.
Before going to the hospital location, take a moment to prepare as a group. What sort of questions will you ask? Which interviewing techniques will you use? Also: review confidentiality.

Logistics
1. Each group will divide into three pairs of students. Each student of the pair will interview one patient while the other watches and evaluates the interview. If there are not enough patients, two of you will team-interview one patient and take turns evaluating each other. Mentors should also observe at least part of the interviews.

2. If possible, choose your partner the week before so you are ready to go this week.

3. Look over the process interview evaluation form in advance. Decide what areas you will try to work on today.

4. The POM-1 office will send your mentors the ward assignment and contact person to find your patients for today – both by e-mail and on the web site.

5. Try to limit the interview to half an hour (45 minutes if you are both interviewing one person). Complete your evaluation of your partner’s interview while he/she is interviewing.
6. **Complete the process interview evaluation form** for your student partner and give him or her feedback.

**SECTION 3: Case Presentations and Discussion** (60 minutes)

1. **Meet as a group** at a preset time to discuss your interviews. Discuss what you learned. What did you learn about interviewing? What seemed to work well? What were your biggest problems? What did you learn about yourself?

2. Each student should now **give a brief case presentation about the patient you interviewed**, using the ‘case presentation’ format. This should be a concise summary including the patient’s view of their illness, and how the illness has affected him or her.

   **You will write up these presentations to hand in next week.** Sample write-ups are attached. Write ups must be word processed.

   **You will receive feedback on:**
   - Chief Complaint
   - History of Present Illness: accuracy, organization and clarity
     - description of characteristics of symptoms or pain, including
       - quality
       - location and radiation
       - duration and timing
       - severity
       - setting and modifying factors
       - associated symptoms
     - clear, concise presentation, usually in temporal sequence
   - Psychosocial context (the patient’s story):
     - patient’s reactions to illness
     - effects of illness on patient’s life
     - effects on patient’s family
     - patient’s coping strategies

3. Feedback from fellow student who observed interview using the process and content form as a guide.

4. Case discussion
   One of the patients interviewed by the students should used for this exercise. The student that interviewed the patient can lead the discussion, but fellow students should contribute to the discussion and answer some of the questions.
(In subsequent hospital interview sessions, a different student should be selected to do this, so all students get an opportunity to lead this exercise)

a. Interviewing
   Were you able to incorporate the following aspects of the interview?
   - Opening
   - Attention to patient’s comfort and privacy while minimizing distractions.
   - Content of interview (chief complaint, history of patient’s illness, the effect of the illness on the patient)
   - Body language and non-verbal communication
   - Feelings (emotional content or overlay of the interview; establishment of rapport between the interviewer and patient).
   - Closing (summarize content, allow for patient question and/or comment, thank patient).

b. Discuss the patient you interviewed.
   - What challenges – medical and social – are they facing now or will they face upon discharge?
   - How are they coping?
   - What may be their experience of their illness and hospitalization?
   - Do you know what their diagnosis and prognosis is?

5. Each student should choose a topic to research for next week. This should be a question that you have about the patient you interviewed. It could be something about the patient’s illness (pathophysiology, treatment, diagnosis, prognosis), the meaning of a patient’s symptoms (what is the differential diagnosis of upper abdominal pain?), or other patient care-related issues. Choose your research question with your group and mentors today.

We expect most students will take 30 minutes to one hour researching their question. Some useful sources include textbooks on MDConsult, WebMD, Wikipedia, etc. Come prepared next week to present the results of your research.

SECTION 4: Evaluation (5 minutes):
How did your hospital interview and presentation go? What would you like to do differently next time?

PRESENTING A PATIENT CASE
Case presentations can have several agendas:

- To acquaint other members of a medical team with a patient and his or her medical issues
- To summarize what you know about a patient and invite others’ ideas about the possible diagnosis, issues, and diagnostic and therapeutic plan
- To make a case for a diagnosis that you suspect or a plan that you advise
- To update members of a medical team about a known patient’s current issues

Case presentations by a student follow a clear format and last between 45 seconds and five minutes. Your mission is that of any speaker: to keep your listeners interested.

The format is as follows:

1. **Brief opening sentence:** patient’s age, gender and presenting issue. Including important health information about a patient (e.g., a major illness, like diabetes) can help “frame” the patient for your listeners. **Example:** Mr. A is a 40-year-old man with right knee pain and swelling for the past two months.

2. **History of present illness:** This is told as a story and should be brief, factual and able to hold listeners’ interest. In case of doubt, be chronological. Include what you think are clues to this “mystery”: for instance, in a patient with knee pain, that it began after he was tackled in a football game and is worse when he goes down the stairs. Include elements of the HPI, when possible.

3. **Past medical history:** Again, this is brief, usually preceded by “is significant for.” **For example:** His past medical history is significant for arthroscopic knee surgery in 1995 and hypertension. He takes no regular medications. Family history is positive for degenerative arthritis in his mother and sister.

4. **Social history:** Include whatever is pertinent to the present problem and a few details that make the patient real. **For example:** Mr. A. is an analyst who works at a desk. He is married with no children. He played college football and plays intramural football every weekend in fall. He does not smoke or drink.

5. **Physical examination:** Includes any abnormal findings and pertinent negative (normal) findings. With a knee problem, this includes the lower extremity examination; it could also include temperature (if you suspect joint infection), back examination (if you suspect his pain is actually radiating from the back); and weight (if you believe obesity is worsening his knee pain). **For example:** He is afebrile and weighs 259 pounds. He has full range of motion in both knees and hips. Right knee has crepitus and pain on full flexion, but no effusion, no warmth, no tenderness. McMurray’s is normal. You will not present any examination findings.

6. **Laboratory and X-ray findings:** You will not present any laboratory or X-ray findings.
SAMPLE HISTORY OF PRESENT ILLNESS (HPI)

Chief Complaint: “I’m here for chemotherapy for my cancer.”

HPI: Mr. X is a 50-year-old man with soft tissue sarcoma. The tumor was discovered five months ago when Mr. X noticed a large lump in his left shoulder. He noted mild (3/10) aching pain in the lump area starting four months ago, worse when he bumped into it accidentally. He had no associated fever, chills or loss of movement in the arm.

The lump grew rapidly, prompting him to seek medical evaluation. An MRI (magnetic resonance imaging) scan confirmed the tumor, and a surgical biopsy diagnosed it as a sarcoma.

Mr. X underwent two cycles of chemotherapy to reduce the size of the tumor. After the second round of chemotherapy, he developed pneumonia and lost his appetite. He lost 20 pounds and became dizzy, weak and fatigued. He also became depressed and began taking medication daily for this.

After he regained 15 pounds, Mr. X underwent surgery to remove the tumor and plastic surgery to reconstruct his shoulder. He is admitted for his third round of chemotherapy.

Also, see an example of a complete history in the appendix (on POM-1 website)
## Practice of Medicine-1
### Process Interview Feedback Form

**Interviewer’s Name** ____________________________

**Evaluators’ Name** ____________________________ **Date**

<table>
<thead>
<tr>
<th>SKILLS</th>
<th>DONE WELL</th>
<th>OK, COULD BE BETTER</th>
<th>NOT DONE OR DONE POORLY</th>
<th>NOT APPLICABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduces self and explains purpose of interview.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Attends to the patient’s comfort and privacy.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Allows patient to describe the illness/chief complaint.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
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<tr>
<td>4. Uses the following techniques effectively (Note: you don’t have to use them all!)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Open-ended questions</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Reflection/Repetition</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Clarification</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Silence</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Facilitators (nods, uh-huh, etc…)</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
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<tr>
<td>Summation</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>OVERALL USE OF INTERVIEWING TECHNIQUES</strong></td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Balances listening with structure.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
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<tr>
<td>6. Follows up on cues and vague statements.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
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<tr>
<td>7. Attends to patient’s nonverbal cues.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
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<tr>
<td>8. Responds empathetically and supportively.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
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<tr>
<td>9. Closes interview appropriately.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
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</tbody>
</table>

**COMMENTS:**

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Practice of Medicine-1
Content Interview Evaluation Form

Interviewer’s name: ____________________________
Observer’s name: ____________________________

<table>
<thead>
<tr>
<th>CONTENT INTERVIEWING SKILLS</th>
<th>DONE WELL</th>
<th>OK, COULD BE BETTER</th>
<th>NOT DONE OR DONE POORLY</th>
<th>NOT APPLICABLE</th>
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<tbody>
<tr>
<td>Defines chief complaint*</td>
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<td>Identifies reason for patient presenting now*</td>
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<tr>
<td>Obtains history of present illness*</td>
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<tr>
<td>Nature of symptom (quality)</td>
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<tr>
<td>Severity</td>
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<tr>
<td>Location (and radiation)</td>
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<tr>
<td>Timing and duration</td>
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<td>Precipitating/aggravating factors</td>
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<tr>
<td>Alleviating factors</td>
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<tr>
<td>Context</td>
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<tr>
<td>Obtains patient’s perspective about illness*</td>
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<td>How it affects them and family</td>
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<td>What patient’s thinks is cause</td>
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<tr>
<td>Determines other active problems/issues*</td>
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