CHAPTER OUTLINE

INTRODUCTION
THE ART OF EFFECTIVE QUESTIONING
Types of Questions
Interwoven Communication Tools to Enhance Patient Responses
• Prompts
• Clarification
• Reflection or Echoing
• Paraphrasing
• Summarizing
The Importance of Nonverbal Language
Motivational Interviewing Concepts
COMMUNICATING WELL WHILE DOCUMENTING

CHAPTER SUMMARY

COMPANION VIDEOS

The following videos are available to accompany this chapter:
• Patient Interviews
**Introduction**

Before describing the categories of the patient interview (see Chapter 4), it is important to point out that the interview process is not linear, nor is it exclusive of the physical tests and measures that contribute to the initial examination. As a student learning this process, it is natural, and often comforting, to have a structured list of questions in hand. You will realize, however, that while a practiced clinician is able to conduct what appears to be a seamless and fluid interview, it is usually guided by each unique patient and not by questions on a form. With experience, clinicians learn to let the interview flow from information the patient offers, minimizing tangents and expanding on particular words, historical events, or even a change in the patient’s facial expression. In addition, there often is considerable overlap in the patient interview and the physical tests and measures.

“The difficulty is not in being exhaustive—all conscientious students have a checklist of questions—but in trying to tailor your verbal approach to the patient and the patient’s problem.”

—Alain Croibier, DO, MRO(F)

Patients may offer information that prompts a clinician to briefly pause the interview to physically observe what the patient has described. For example, a patient may say, “When I’m walking, my hip seems to twist and pop.” The clinician then may say, “Would you mind showing me what you’re talking about?” (encouraging the patient to stand and walk). Based on what the clinician sees, this may lead to more specific questioning, or the clinician may make a note to him/herself about specific tests and measures that should now be performed (the priorities). Likewise, a finding during the physical examination may prompt further questioning about the patient’s story. For example, during a gait assessment with a patient being seen for Parkinson’s disease, a clinician notices a small wound on the plantar surface of the patient’s foot that the patient seems unaware of. This would then prompt a short detour with additional questions about the patient’s health, particularly directed toward the possibility of diabetes.

Understand that even if everything goes as planned during the initial patient interview, additional important information will likely be acquired in subsequent sessions. Both you and the patient may think of topics that should have been discussed well after the first session has ended. This is one of the benefits of the physical therapy profession. Patients are usually seen frequently, so conversations can progress from visit to visit and information can be gathered on a continual basis. Between sessions, encourage patients to write down questions, concerns, or areas of confusion that can be discussed at the next appointment. Likewise, you should make notes to yourself about patients as they arise (although you are encouraged to avoid multitasking when working with patients, it is not uncommon to suddenly think, “Oh, I forgot to ask Mr. Smith about ____” while you are working with Mrs. Jones). Carrying a pack of sticky notes can be helpful in this regard.

**THE ART OF EFFECTIVE QUESTIONING**

**Types of Questions**

A vast amount of information can be gathered in a very short time during a patient interview. How to sort that information and decide what is important and what is not takes considerable practice. You might consider yourself acting as a coin-sorting machine throughout the interview. Not so odd if you think about it. A jar full of coins is dumped into the machine, and these coins are then sorted. The most valuable are the dollar coins; the least valuable are the pennies. Throughout an interview, the information provided by a patient can be similarly sorted into most and least valuable. The “dollar statements” will provide you with the most insight, the “penny statements” with the least, and the “dime statements” somewhere in between. The dollar statements will be your areas of focus as you dig deeper into the patient’s story. The penny statements can be tucked away in your back pocket to be pulled out should the need arise.
What follows are descriptions of types of questions that should be used during a patient interview.2–7

Open-ended questions are those that invite the patient to answer with a narrative response. These are the questions you should use to begin the interview or to begin new topics within the interview.

The first open-ended question, typically used after greeting the patient, is the opening question. This question should be asked in a way that invites the patient to describe his or her primary concerns or reasons for seeking a physical therapy consultation. Examples include “What brings you to physical therapy today?” or “What problems/concerns are you having that I can help you with?” Although it is common for patients to present to physical therapy with a referral from a physician, you should never assume that the diagnosis or condition listed on the referral is congruent with the patient’s primary concern(s). (See BOX 3-1.) Therefore, allowing the patient the opportunity to voice his or her reasons for seeking care will usually provide the best direction for the remainder of the examination.

Following the opening question, additional open-ended questions should be employed to allow the patient further opportunity to describe his or her primary concerns. Examples include:

• “What can you tell me about your shoulder pain?”
• “Would you tell me about your balance problems?”
• “Will you describe how your multiple sclerosis (MS) has changed what you are able to do on a daily basis?”

Using open-ended questions with patients who are quiet or reserved may encourage them to open up.

Closed-ended questions are those that require a very definitive, or a yes or no, response. Based on a patient’s response to an open-ended question, you can use one or more closed-ended questions to obtain more specific information or to clarify the patient’s answer. Examples based on the previous open-ended questions include the following:

• “Is your shoulder pain present all the time?”
• “Have you fallen because you’ve lost your balance?”
• “Have you had to stay home from work because of your MS?”

If patients are very talkative and tend to go on numerous tangents, using more closed-ended questions may help to focus the interview.

Graded-response questions are those that will provide you with a better illustration of a patient’s condition or ability. A patient may say, “The pain gets worse when I sit for a long time.” While this is good information to have, your understanding of “a long time” may be far different than the patient’s. Therefore, following up with “How many minutes can you sit before the pain starts to get worse?” would provide you with more helpful information and would ensure that you and the patient have a mutual understanding. In addition, this specific information might be used in one of your physical therapy goals (to increase tolerable time in sitting from x to y minutes). Without this specific information, setting a physical therapy goal would not be possible. (“The patient will report being able to sit longer …” is not a measurable goal.) Other examples of graded-response questions include the following:

• Patient statement: “I get short of breath when I go up stairs.”
• Follow-up: “How many stairs can you go up before you become short of breath?”
• Patient statement: “I can’t walk to the store anymore because my knee hurts.”
• Follow-up: “How many blocks can you walk before your knee begins to hurt?”

BOX 3-1 An Example of Why Patients Should Be Allowed to Describe Why They Are Seeking a Physical Therapist’s Care

A patient was referred to physical therapy by her primary care physician. She presented to an outpatient physical therapy clinic with a referral that read, “PT eval & treat; © shoulder pain.” After greeting the patient, the physical therapist opened the interview with “I see you have pain in your right shoulder. What can you tell me about that?” The patient described some concerns with the right shoulder, the physical therapist performed a thorough examination based on the patient’s description of the problem, and the patient was given a home exercise program. At the end of the session, the physical therapist asked the patient if she had any questions. The patient was hesitant, but replied, “What about my hip?” Confused, the physical therapist stated, “I wasn’t aware you were having trouble with your hip. Did your physician want you to come to physical therapy for your hip as well as your shoulder?” The patient responded that hip pain was her main concern and the primary reason she saw her physician. The physician had, in fact, written a separate physical therapy referral for hip pain, but that had been inadvertently stapled to written orders for diagnostic testing. Thus, because the physical therapist’s focus was based on the referral for shoulder pain, an entire clinic session was spent on an issue that was not the patient’s primary reason for seeking physical therapy care.
• Patient statement: “I have to sit and rest a lot while I’m making dinner.”
• Follow up: “How many minutes can you stand without having to sit?”

Multiple-option questions, in which a few options are made available to patients, are helpful when they may have difficulty coming up with an answer on their own. Many patients find it challenging to describe pain.⁵ They just hurt! Knowledge about the type of pain a patient experiences often helps a clinician narrow the source of the pain. Dull, achy pain is commonly associated with soft tissue or muscular dysfunction, throbbing or pounding pain may have a vascular origin, and shooting or stinging pain often is neurogenic.⁸ Therefore, when asking patients to describe their pain, it is appropriate to offer options: “Would you say that your pain is dull, sharp, throbbing, or burning?” Likewise, some patients who have experienced incredibly life-altering injuries or illnesses, such as a stroke or a spinal cord injury (SCI), may need help focusing on specific functional difficulties. For example, if a patient hesitates, seems confused, or simply states “everything” when asked about functional activities that are difficult or impossible, you can offer short lists to help patients focus. You might ask, “Do you have trouble getting dressed, preparing meals, or bathing?” or “Is it difficult to get out of bed, get out of a chair, or get into or out of a car?” These short lists might help a patient remember activities that have been particularly difficult. You then can explore each activity individually for more information. Asking about multiple things at one time should only be used for the purpose of helping patients better describe or remember things. Asking multiple questions in one sentence in an attempt to save time or take shortcuts should be avoided.

“The single biggest problem in communication is the illusion that it has taken place.”
—George Bernard Shaw

Interwoven Communication Tools to Enhance Patient Responses
The following communication tools can be used throughout the patient interview to facilitate the conversation and add clarity to the dialogue.²–⁴

Prompters
Prompters can be verbal or nonverbal. They are used to encourage the patient to keep talking and to assure the patient that you are listening. Examples of verbal prompters include “I see,” “Uh huh,” or “Go on.” Examples of nonverbal prompters would be an attentive nod, a slight shift forward in body position, or a curious facial expression.

Clarification
Clarification can be used to ensure that you understand a term or phrase used by a patient. For example, a patient may say, “I have migraines about every other day.” Knowing that typical migraine headaches do not occur with that frequency⁹ and that patients often have a very different understanding of some medical terms compared to medical personnel,⁴¹⁰ you may clarify the patient’s statement by saying, “Can you tell me what you mean when you say ‘migraines?’” Be careful not to ask this in a condescending tone, implying that the patient does not know the medical definition of the term.

Reflection or Echoing
This technique involves repeating a word or a phrase that a patient has used in a manner that encourages the patient to elaborate with additional details or information. For example, a patient may state, “I get a weird feeling in my leg when I bend over.” While it is helpful to know that a symptom can be provoked by a certain movement, “a weird feeling” can mean any number of things. A reflective response that encourages the patient to provide additional information is, “A weird feeling?” Another example would involve a patient’s saying, “That medication makes me feel crazy!” A reflective response of “Crazy?” invites the patient to describe exactly what he or she means.

Reflective Feeling
Patients often express feelings and emotions when answering questions or telling their story. In addition to reflecting words the patient uses (described above), it is also sometimes helpful to acknowledge and affirm the emotion being expressed. A patient may state (in an angry or frustrated tone), “I don’t understand why anyone can’t tell me what’s wrong with my back. My doctor won’t order an X-ray or give me any more pain pills. No one seems to care that I’ll lose my job if I miss any more work!” An appropriate reflective feeling response, offered in a calm tone, would be “It sounds...
like you’re frustrated to have unanswered questions about your back pain, and you feel disappointed that your doctor isn’t doing more to help you. It also sounds like you’re fearful about losing your job if your back pain doesn’t improve.” Acknowledging a patient’s emotion surrounding a situation, simply a different way for the patient to feel “heard,” can go a long way toward enhancing rapport.

**Paraphrasing**

*Paraphrasing* is using your own words to describe something a patient says. This technique is used to ensure that there is a mutual understanding of what the patient has said. For example, a patient might say, “My foot drags every time I take a step and then sometimes it catches, usually when I hit carpet, and I trip. I can catch myself most times, and boy do I like it when there’s a wall or couch there, but sometimes I end up on the floor.” This can be paraphrased with, “So it sounds as if your foot dragging on the floor causes you to lose your balance and sometimes you end up falling. Is that correct?”

**Summarizing**

*Summarizing* is a means of providing the patient with a compressed version of a particular topic or of the global conversation as you have heard it. This is very important to provide at the end of the patient interview, but can also occur several times throughout. Here, you are blending the “dollar statements” you have heard into several summary sentences. This helps the patient feel confident that you have a good picture of what has been discussed. It also offers the patient an opportunity to mention things he or she forgot, or an opportunity to restate or reinforce something you did not include in the summary.

You may or may not use all of these communication tools during the course of any one interview, but knowing their purpose and understanding when each is appropriate to use can greatly enhance the quality of your patient interviews. Just as there are techniques to learn and foster, there are also interviewing practices that should be avoided. These are summarized in **Table 3-1**.

**Table 3-1 Interviewing Practices to Avoid**

<table>
<thead>
<tr>
<th>Interviewing Practice</th>
<th>Examples</th>
<th>Why This Should Be Avoided</th>
<th>Better Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking multiple questions within a question</td>
<td>“Have you had any difficulties performing your job duties, or tasks at home, or spending time with friends?”</td>
<td>This will either confuse patients or they will only attend to one part of the question and avoid or forget the rest.</td>
<td>Ask each question separately, allowing time between questions for the patient’s response.</td>
</tr>
<tr>
<td>Asking leading questions</td>
<td>“Is your pain worse at night?” or “What have you needed extra help with since your heart attack?”</td>
<td>This gives the impression that you expect a particular answer. In the first example, the patient may assume that pain should be present (or at its worst) at night; in the second example, the patient may think that he or she should need help when it is possible that no help is required.</td>
<td>“What time of day is your pain at its worst?” or “Has the heart attack changed how well you are able to do things on your own?”</td>
</tr>
<tr>
<td>“Closing” an open-ended question</td>
<td>“Would you tell me about your balance? Have you fallen in the past few weeks?”</td>
<td>Asking an open-ended question that is immediately followed by a closed-ended one discourages a narrative response and tells the patient you are only concerned about the answer to the closed-ended question. In the example, there are many aspects of the patient’s balance about which he or she could elaborate (e.g., loss of balance without falling, stumbling, fear related to falling), but the patient will only focus on actual falls based on the closed-ended question. Allowing the patient to answer the open-ended question may provide the answers to many possible closed-ended ones.</td>
<td>“Would you tell me about your balance?” (Allow the patient to fully answer the question.) If a report of falling is not included in the answer, then ask, “Have you fallen in the past few weeks?”</td>
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(continues)
Interviewing Techniques and Communication Tools

Chapter 3

TABLE 3-1 Interviewing Practices to Avoid (continued)

<table>
<thead>
<tr>
<th>Interviewing Practice</th>
<th>Examples</th>
<th>Why This Should Be Avoided</th>
<th>Better Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking questions that begin with “Why?”</td>
<td>“Why do work activities make your neck pain worse?” or “Why can’t you mow the lawn anymore?”</td>
<td>“Why” questions can be perceived as accusatory and tend to put patients on the defensive.</td>
<td>“What is it about your work duties that increase your neck pain?” or “What specifically about mowing the lawn makes that difficult for you?”</td>
</tr>
<tr>
<td>Overreacting to potentially concerning information or content of patient responses</td>
<td>Example 1: A patient describes signs, symptoms, and pain patterns consistent with those of cancer, prompting you to say, “I think we need to stop the examination here so I can call your physician.” Example 2: In response to a question about self-management of pain, a patient indicates use of an illegal substance. Your response is a disapproving or surprised facial expression, or “Seriously?”</td>
<td>Comments that indicate your elevated concern, in particular if it concerns a medical condition, might alarm the patient or cause substantial anxiety. Likewise, patients who observe or perceive your disapproval or judgment may become angry, refuse to cooperate further, or may not return for future sessions.</td>
<td>Example 1: “I would like to let your physician know about some of the things I’ve learned so we are all on the same page.” Example 2: Use a facial expression that simply acknowledges that you heard the information—this may take a great deal of self-awareness and self-reflection as many of our facial expressions/gestures may occur subconsciously and spontaneously.</td>
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The Importance of Nonverbal Language

“The most important thing in communication is hearing what isn’t said.”

—Peter F. Drucker (1909–2005)

Nonverbal language, including facial expressions, hand gestures, and body posture, can enhance or reinforce our verbal communication. This is a two-way street. Just as you should have a strong self-awareness of the messages you are conveying nonverbally, be attuned to the messages your patient is sending back to you. Realize that this must begin the moment you encounter the patient, as it typically takes less than one second for individuals to identify emotions from observed nonverbal behavior.11 BOX 3-2 provides a description of common nonverbal behaviors that are generally received in a positive or negative manner. Use of the positive nonverbal cues indicates open and safe communication whereas use of the negative nonverbal cues suggests closed and unsafe communication.2,12 Use of several positive or several negative nonverbal cues together conveys a stronger message. For example, simultaneously leaning back with your arms crossed, this may make the patient unsure of your level of interest or agreement.

In addition to positive and negative nonverbal messages, you should be aware of any habitual hand gestures you use. We live in a diverse nation with people visiting or immigrating from all over the world. Just because an individual has chosen to reside in the United States does not mean that he or she will adopt or understand gestures or practices common in this country. If you were to visit another country and someone raised his or her middle finger to you, your immediate reaction would be to take offense. However, this gesture may not have the same meaning abroad as it does in the United States. Similarly, gestures or body positions that are considered positive or neutral in the United States may be interpreted as highly offensive to a patient from another country. TABLE 3-2 describes some of these gestures that you should be aware of.

Motivational Interviewing Concepts

Motivational interviewing is a specialized type of interviewing that has an underlying purpose of encouraging behavioral changes; in the health care setting, these changes most commonly revolve around beliefs and practices that lead to or perpetuate chronic health conditions.13 Examples include the behavior of making poor dietary choices when one has type 2 diabetes, the behavior of smoking when there is a strong family history of lung cancer, or the behavior of avoiding the use of an assistive device when there has been a history of falls. A clinician would be making false things a patient says but at the same time you sit leaning back with your arms crossed, this may make the patient unsure of your level of interest or agreement.
assumptions about these patients if he or she thought that lack of motivation or willpower were the central reasons for the unhealthy behaviors. Motivation and willpower may be components, but often patients lack adequate understanding of how the behaviors negatively influence the health conditions, or they lack an understanding of how they can change these behaviors. Motivational interviewing can be instrumental in helping patients gain this understanding and empowering them to change behaviors.

Core components of motivational interviewing include exploring the patient’s own motivations, listening with empathy, using open-ended questions, and encouraging patient autonomy. It is a conversation directed at helping the patient formulate his or her own argument for change, not forcing the argument upon the patient.

A thorough description of motivational interviewing is beyond the scope of this text. In addition, it is usually necessary for students to have (1) at least a moderate understanding of the anatomical, physiological, pharmacological, and psychological aspects of various disease and conditions before motivational interviewing can be effective, and (2) enough patient care experience to understand the complex biopsychosocial dynamic of patients and their health conditions. As a novice, you may easily recognize that the behaviors mentioned above—poor dietary choices, smoking, and avoidance of an assistive device—must change to

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**BOX 3-2  Positive and Negative Nonverbal Behavior**

Positive Nonverbal Behaviors
- Relaxed posture
- Arms relaxed and uncrossed (palms up is a sign of openness)
- Good eye contact (although you should avoid staring)
- Nodding agreement (should only correspond to particular statements; continual head bobbing indicates boredom)
- Smiling and adding appropriate humor
- Leaning closer (indicates interest is up and barriers are down)
- Hand gestures that complement speech (using open hands is most effective; exaggerated “talking with your hands” is distracting)

Negative Nonverbal Behaviors
- Body tense
- Arms crossed over chest (creates a barrier and can express defiance, resistance, or power)
- Furrowed brow (indicates disapproval especially in combination with narrowing of the eyes)
- Yawning (indicates boredom)
- Blank or unchanging facial expression (indicates nothing the speaker says is of interest to you); frowning
- Leaning away (indicates disapproval or that you are uncomfortable with the speaker)
- Clenched fists
- Fidgeting, finger tapping, eyes wandering from place to place


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![FIGURE 3-1](image)

(a) Example of combined positive nonverbal cues. (b) Example of combined negative nonverbal cues.
improve a patient’s overall health status, but you may not have the tools to help patients understand how and why to make better choices. Because of its known benefits in helping patients to change undesirable behaviors, you are strongly encouraged to develop skills in motivational interviewing as you progress through your educational program.

**COMMUNICATING WELL WHILE DOCUMENTING**

Documenting what patients say while trying to be engaged and attentive toward the individual is often extremely challenging for students. In the early stages of learning this skill, your tendency will be to write nearly everything the patient says on your examination form. This is natural, as your clinical reasoning is not developed enough to know what is important and what is not, and you are afraid to miss important details. However, if you do this, you will find yourself looking down at the form (or at the computer screen) and scribbling (or typing) during the entire interview (see **FIGURE 3-2**). This leaves little time for putting all of the good communication tools described earlier into play. The risk of this practice increases if you use an examination form that contains every possible interview question. In your haste to get through all the questions, you might find yourself asking the next question as you finish writing the answer to the previous question without taking your eyes from the form. At minimum, this makes the interview feel cold and disconnected. A worse possibility is that you miss facial expressions or body language that might provide valuable information. Another negative outcome is that you fail to follow up on key patient comments because those comments do not seem to fit any question on your list, so you (regretfully) dismiss them.

Clinicians develop their own style of interviewing that continues to transform long after they have obtained a license to practice. Some develop the ability to conduct an entire patient interview without writing more than a few words on an exam form. Expert clinicians who are able to do this take a true interest in the patient, and the memory of the patient’s story can be easily recalled at a later time with just a few key reminders. Other clinicians opt to write a substantial amount of information on the exam form, but

**FIGURE 3-2** Example of a clinician intently focused on a computer screen, lacking focus on the patient.

### TABLE 3-2 Common U.S. Hand and Body Gestures to Avoid

<table>
<thead>
<tr>
<th>Common U.S. Hand Gestures</th>
<th>Possible Interpretation in Other Countries</th>
</tr>
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<tbody>
<tr>
<td>Making the OK sign (finger and thumb forming a circle; digits three to five extended upward)</td>
<td>Considered an obscene and rude gesture in Brazil, Russia, Spain, and Greece; considered to mean “worthless” in France</td>
</tr>
<tr>
<td>Snapping the fingers of both hands</td>
<td>Considered rude in France</td>
</tr>
<tr>
<td>Tapping the two index fingers together</td>
<td>Considered an invitation to sleep with you in Greece</td>
</tr>
<tr>
<td>Pointing at someone with your index finger</td>
<td>Considered very rude in many countries of Asia</td>
</tr>
<tr>
<td>Giving the thumbs up sign</td>
<td>Considered an obscene and offensive gesture in West Africa, Australia, South America, Greece, and Middle Eastern countries</td>
</tr>
<tr>
<td>Beckoning with the finger (“come here”)</td>
<td>Considered an indication of death in Singapore and Japan</td>
</tr>
<tr>
<td>Crossing the middle finger over the index finger (good luck sign in the United States)</td>
<td>Considered sexually obscene in several Asian and African countries</td>
</tr>
<tr>
<td>Making the V sign with the middle and index finger (the U.S. victory or peace sign) with the palm facing toward the person making the gesture</td>
<td>Considered on obscene gesture in England</td>
</tr>
<tr>
<td>Putting hands on hips</td>
<td>Signals hostility in Mexico</td>
</tr>
<tr>
<td>Showing the bottom of your shoes or feet</td>
<td>Considered insulting and rude in many countries of Asia, Africa, and the Middle East</td>
</tr>
</tbody>
</table>

they wait to do so until the patient has answered several related questions; the clinician allows the patient to answer completely and then writes a summary of the patient’s important statements on the form. The latter technique is much easier for students to adopt initially and is the one suggested at this point in the learning process. Consider the following example.

Imagine you are interviewing a patient with acute low back pain. In answer to your question “Have you had any similar episodes of lower back pain prior to this one?” the patient lists a number of previous incidents and gives some details for each. As the patient is talking, you diligently scribble on your examination form:

Dec ’14 bent over to lift box of Christmas decorations—maybe 10#; Jan ’15 shoveling snow; Sept ’15 digging a hole to plant tree—happened when only ½ of the hole was finished; March ’16 picking things up from floor—clothes and kids’ toys; Sept ’16 bent over to tie shoe

An experienced clinician, however, might ask the same question, wait for the patient to answer (while observing the patient and maintaining eye contact), and then write the following:

5 past episodes of similar injury between ’14 and ’16, all in a flexed lumbar position (with variable exertion/lifting)

In this case, the clinician with experience is able to summarize the information provided by the patient into a useful “chunk” but also is able to use active listening. How rapidly you are able to develop this skill will depend on many factors, but thinking about the patient’s responses as a story versus a list of items may be helpful in this regard. You also may decide, during the learning process, that this technique is not for you. Recall that you are not being asked to conform to any strict method of patient interviewing; maybe your drum beats quite differently than many others. You are, however, being asked to keep the interview focused on the patient and make the patient the most important thing at that time. How you go about doing this will ultimately be up to you.

CHAPTER SUMMARY

Communication during the patient interview goes far beyond a list of questions you need to ask. The types of questions you opt to use, as well as the manner in which you ask them, can foster open and informative conversation. There are several interviewing practices to avoid, including the use of negative nonverbal behaviors and gestures that could be interpreted in a disapproving manner; these things can quickly close down a conversation. The ability to listen to a patient, hone in on the key phrases, and then briefly document a summary—all while paying close attention to the patient—is a skill that is not always easy to develop, but it will promote more efficient examinations and improved patient rapport.

REFERENCES
