"What Else?" Setting the Agenda for the Clinical Interview

Let's consider this all too-common ending of a medical interview:

Dr. A.: Well, Ms. X., it looks like that head stuffiness is just a bad virus cold and not a bacterial sinus infection, so I think we're going to have to wait it out. Antibiotics don't help with viruses and really could cause more trouble, so I don't think we'll need them.

(He stands and moves to the door, his hand on the doorknob.)

So I'm glad it wasn't anything worse. Let me know if it seems to be hanging around more than another week or if anything else develops.

Patient: Yes, thanks, Doctor. But before you go, there is one other thing.

Dr. A.: Yes?

Patient: Well, it's just that I've been having blood in my bowel movements. It isn't all the time, but sometimes the bowel movement is mixed with a lot of blood and I was just wondering if I should do anything about it.

Dr. A.: I don't believe it. Really?

Patient: Yes. Why? Is it something serious?

Dr. A.: Well, yes, it could be. And I wish you had mentioned it before. Why didn't you tell me before?

Patient: You didn't ask me.

In the United States, this frustrating interaction is usually called the "Oh, by the way, Doctor" interview syndrome, or the "doorknob question" because the doctor frequently is on her way out the door, hand on the doorknob, when the question arises. The French often call it the *à propos*, *Docteur*" question; the Dutch may call it *tussen haakjes* ("between 2 brackets" or, as we might say, "parenthetically"); and Barcelona physicians suggest that it is another case of *puayque*, eliding the patient's "*Pues, ya que estoy aquí. . .*" ("Well, since I am still here. . ."). Observers note that the syndrome occurs at the end of the interview, but we believe it has its origin at the beginning, when agenda setting occurs. Although clinicians tend to blame the patient for this distressing syndrome, in fact it is frequently the result of defective interview technique: failure to elicit the patient's entire agenda early in the visit (1).

If the physician jumps into an exploration of the first problem the patient mentions before knowing all of the patient's worries, he will often be confronted with these unvoiced concerns at the end of the interview (2, 3). Open-ended questions, such as "What else?", "What other problems do you want us to attend to today?", "Besides the cold symptoms, what other concerns do you want us to attend to today?", " What else did you want to accomplish here today?", and even, "What specific requests do you have today, such as for prescription refills, referrals or forms that need to be completed?" are most helpful in eliciting the patient's entire list of concerns. Once the physician has a clear picture, she may find it necessary to prioritize those concerns and negotiate how and when they will be attended to, since time limitations may prevent her from covering all of the issues at that visit. Differences of opinion about what should be done demand further negotiation.

Incomplete and incorrect agenda setting seems quite common in medical interviews. Stewart and colleagues (4) reported that 54% of patients' symptoms and 45% of their concerns were not elicited. In 1981, Starfield and associates (5) found that in 50% of visits, the patient and the doctor did not agree on the nature of the main presenting problem. Burack and Carpenter (6) found that the patient and the doctor agreed 76% of the time if the chief symptom was physical and only 6% of the time if it was psychosocial. Although these studies are decades old, Marvel and colleagues (3) found similar problems in 1999, showing that even accomplished family practitioners interrupted their patients an average of 23 seconds into the interview and often prevented patients from fully voicing their initial symptoms. The Bayer Institute for Health Care Communication has provided half-day workshops for clinicians since 1990. One workshop, titled "Clinician–Patient Communication to Enhance Health Outcomes," asks clinicians to name their most frustrating clinical encounters. High on the list of frustrations named are the problems caused by incomplete agenda setting, such as the "Oh, by the way, Doctor" syndrome and the "positive review of systems" syndrome.

Why do physicians so often fail to elicit a complete account of their patients' concerns? Time pressures are part of the problem. As physicians feel more and more oppressed by lack of time, they may spend even less time eliciting the patient's agenda, hoping to face only a single issue and believing that the sooner they begin the problem work-up the better. Many believe that the model of a complete interview consists of a single chief symptom, further elaboration of the history of that symptom, a family history, a personal medical history, a personal social history, a drug and allergy history, and finally a systems review (7). Unfortunately, this preferred format does not match the reality of many visits, in which patients bring more than one symptom and want attention and advice about each (8).

Another cause of our failure to elicit complete agendas is the assumption that the patient will begin his story with the most bothersome or most important issue. Quite the opposite is true. We may blame the patient and call his other concerns part of a "hidden agenda," but the problem could equally well be ours: We lack a complete understanding of the patient's concerns, and his first-voiced concern is often not his most pressing one (6, 9). If the most bothersome symptom is biomedical, it will probably not be voiced first about 50% of the time. If the chief symptom is psychosocial, it is even less likely to come up first. Thus, it

is important for the physician to ask for a complete list of concerns before delving deeply into the first one mentioned. Suppose our Dr. A. had done this.

Dr. A.: Hi, Ms. X. What brings you in to see me today?

Patient: Well, I think I've got sinus again, Doctor. My head is all stuffy and my nose runs all the time and I've got a sore throat and I'm hoarse.

Dr. A.: I see. Lots of upper respiratory symptoms. Anything else? Any other concerns that you want me to address today?

Patient: No, not really. Except maybe. . . .

Dr. A.: Yes? Except what?

Patient: Well, it's a little embarrassing, but for a couple of months, every so often, I get blood when I go to the bathroom.

Dr. A.: Blood? In your urine? Or in the stool?

Patient: The second, Doctor. Mixed in, there is red blood.

Dr. A.: I see. So there's the sinus trouble and there's blood in your stool. Anything else?

Patient: No, that's it. Just those two.

Dr. A.: I see. Well, we'll try to deal with both, but first let me ask you some more questions about your intestines.

Patient: OK.

This dialogue would have precluded the shocking discovery at the end of allotted time that the doctor has to start all over again.

KEYS TO ESTABLISHING THE AGENDA

The following 5 questions can help to identify the agenda for the visit: 1) What are the patient's main concerns for today? 2) What are the clinician's concerns about this patient? 3) What are the patient's specific requests? 4) How much of the patient's or the doctor's concerns need to be addressed today, and which ones or parts of ones can be deferred to a subsequent contact? 5) What disagreements about priorities exist, and how will they be negotiated?

From our patients' perspective, our cardinal flaw as clinicians consists of neither listening to nor understanding their issues. Our first tasks must be to perform those 2 acts and demonstrate to our patients that we have indeed listened and understood (10, 11). Medical assistants or nurses can start this process by asking the following questions: 1) What were the main concerns you wanted to discuss with the doctor today? 2) What other concerns do you have? 3) Do you have any specific needs for us to take care of today, such as prescription refills, referrals, or forms that need to be completed?

After an opening greeting, the physician can probe for any additional concerns and requests:

I see that my medical assistant wrote down that you are bothered by a sore throat and a stuffy head and that you also need refills of two medicines. Was there anything else that you wanted to cover today?

PRIORITIZATION AND NEGOTIATION

After the physician has clarified the patient's agenda, physician and patient, working together, may need to prioritize the list and negotiate which parts will be dealt with that day. Patients may have their own reasons for wanting resolution of an issue that does not appear at first to be of high priority to the doctor. The doctor should obtain explicit agreement, therefore, before assuming unilaterally which items to cover and which to postpone.

Of the three things you wanted us to cover today, I think we should start with your chest pain as that is potentially most dangerous. We want to make sure we do justice to that important concern, and we may want to defer the other two issues to a follow-up visit.

Many times, the patient has a question that can be answered simply and quickly. The doctor can ask, "Was there a specific question that I might be able to answer for you quickly right now, or should we set aside more time to address that fully at a follow-up visit?" The patient might then ask for something simple, such as a signature on a disabled-parking form.

Failing to define the patient's agenda may lead to other interview problems besides the "Oh, by the way, Doctor" syndrome. Most physicians have had a patient whose review of systems is positive; important problems keep surfacing during its elaboration. But "what else?" questions shorten and organize the multiproblem patient presentation by moving issues that are current and important to an earlier place in the complete history, thus emptying the review of systems of important issues. Patients may have several health and psychosocial concerns but expect only a few to be the focus of their current visit. Agenda setting helps to identify this manageable subset for the current encounter.

Does this take more time? Just the opposite! Failure to comprehend each other's goals for the visit is a common cause of a dysfunctional consultation that ends up requiring more time (11, 12).

AGENDA-SETTING LANGUAGE

Some well-tested phrases can help physicians address the challenges of setting the clinical agenda (13). Consider these samples.

What Are the Patient's Main Concerns about His Health Today?

To begin the visit, the physician could ask the following questions: 1) What brings you to see us today? 2) What sorts of troubles are concerning you today? 3) What else did you want to discuss today? 4) Other than problems x, y, and z, what else did you want to be sure we begin to address today? 5) What else did you need to have taken care of today?

Sometimes patients have agenda items that clinicians may wish weren't there or were stated differently. Often they come as requests: "I need a referral for an MRI," "I

need you to send me to a specialist," or "I need you to double my prescription for pain medication." Although the patient presents these requests as agenda items, often as answers to such queries as "What brings you in today?" or "What can I do for you today?", they are really statements about the patient's idea of what the outcome of the interaction should be. As such, patient and doctor may need to participate in much discussion and negotiation. During agenda setting, however, the key is to remain in the agenda-setting mode and collect the patient's concerns, no matter how troubling they are to the clinician. Once all the cards are on the table, the clinician can begin a discussion about the disagreement. One can paraphrase the patient's request in terms of a discussion.

So, we need to talk about your desire to have an MRI. What else?

We need to explore how a specialist might help us manage your blood pressure. What else were you hoping to accomplish?

We clinicians are sometimes too ready to interrupt the patient's agenda setting and embark on a differential diagnosis or an argument about therapeutic and diagnostic measures. We should initially limit ourselves to triage questions and guard against prematurely attacking one item in great depth.

For now, I want to be sure I understand how important this concern is to you. We will be going into the details in a moment.

I want to come back to that, but first I want to get all these concerns in order of importance.

What Are the Clinician's Concerns?

Even though the clinician's concerns may have prompted the visit, the patient is still the one who decided to come in for the appointment and will probably have additional questions or needs that he wants addressed. Once again, the steps are first to elicit all of the items on the "wish list" for the current visit and then to prioritize and negotiate how much and in what order they will be addressed.

I know I asked you back so I could recheck your blood pressure and listen to your lungs, and I heard you say that you were quite concerned about your sore foot. If it's OK with you, I think we can listen to your lungs again, discuss your blood pressure readings, and then take a look at your foot. Sound reasonable?

What Are the Patient's Most Important Tasks?

The doctor can use statements like the following to determine what is most important to the patient.

There are a lot of issues for us to address. What were you most hoping we could accomplish today? We can make a plan for handling the rest later.

What were you hoping I might be able to do about that today?

What is the one thing you want to be sure happens before you leave here today?

I see that you have several concerns today. Can you tell me what goes on the top of your list?

I see you brought a list in today. Let's decide where to begin in case we run out of time.

What Must Be Attended to, and What Can Be Postponed for Future Visits?

This step involves melding your concerns with those of your patient, prioritizing the issues, and negotiating. Finally, you must check for understanding and for agreement (14). The clinician may need to take the lead in prioritizing the list and may add items depending on his follow-up concerns and health maintenance issues. The key is that clinician and patient treat each other's concerns with respect and efficiently negotiate which items they will address in the visit before beginning to work up any specific concerns.

I want to make sure I've heard all your concerns, and then we have to decide together what we can do today, which concerns to tackle, and perhaps which to save for another time.

What if Further Negotiation Is Necessary?

What about disagreements regarding the agenda, its priorities, and how much can be addressed during the current visit? Much that appears to be disagreement about the agenda is really a disagreement about the final steps of care. These disagreements still need to be addressed, as do those about timing and costs. Patients may have saved up a list of issues to be discussed in a single visit, following popular advice that patients should make a list and organize their questions or even hoping to save the bother and expense of future visits. Thus, if the disagreement is about a plan, the following conversation would be helpful.

Doctor: So my understanding is that you thought a MRI study would be a good idea.

Patient: Yes, exactly.

Doctor: And I'm thinking we should try heat and an anti-inflammatory medicine first.

Patient: Uh-huh.

Doctor: So it looks different to each of us. What shall we do?

Patient: You don't think I should have an MRI?

Doctor: Maybe not. It all depends on how you respond to the medication. What if we did that first and then I talked to you in three days to see how you were doing? We could consider further tests then.

Patient: I guess that would be OK.

Doctor: Fine. That's what we'll do.

Or, if the disagreement is truly about time management, the physician could say, "I know you were concerned about your knees and the rash and the hoarseness, and I think I need to focus on that chest pain first. We may not be able to do justice to all these issues today, but I think the chest pain could be the most dangerous, so we should attend to it first. Does that sound OK?"

Results of Agenda Setting

Sometimes patient discussion becomes tangential during a visit. Clinicians searching for a way to bring the conversation back to a more productive track will find an empathic bridge helpful. It is easier to interrupt a patient and return him or her to the purpose of the visit if we have previously established an agenda and identified the patient's top priorities.

If our clinician has asked her patient about his arthralgia, the patient might begin to digress:

> In general, my hands are feeling a bit better. I was able to use my pruning shears in the garden over the weekend. And, oh my, did I need to prune! The aphids had really gone after the roses. And I didn't want to use all those toxic chemicals. Sometimes I make a light solution of dish soap and spray it on. But of course that doesn't do anything about the beetles. . . .

When the clinician decides it is time to come back from the garden and return to the agenda of the visit, she starts by reflecting or paraphrasing what the patient has just said to anchor the discussion in the patient's experience: "It sounds like you spend a lot of time working in the garden." The reflection may include or be immediately followed by an empathic statement: "And it has brought you a lot of pleasure." This provides the patient a place to return to that is his. The clinician has built an empathic bridge to help the patient return to the clinician's priorities. The clinician could then say, "I know you wanted to be sure we discussed the best dose of anti-inflammatory medicine for you."

Investing the time to develop a mutual agenda at the beginning of the visit helps the patient and clinician agree on mutually important concerns. If some items defined early on cannot be addressed that day or if the patient should later have additional questions, concerns, or requests, the clinician can ask that the patient schedule further appointments or identify other resources.

Mr. Smith, I think we've done justice to the agenda we agreed upon at the outset, and I want to be able to give similar attention to the items we've left out. I suggest that we make a follow-up appointment and then we can reassess how you are doing and evaluate these other concerns at the same time. Sound reasonable?

The patient may believe that his remaining questions are easy and can be answered quickly. The clinician may give herself permission to respect the time boundaries of the appointment but may want to first check on the complexity of the patient's last concern:

Is there a single question that I may be able to answer about that right now?

At times, it will make sense to accompany setting time limits with a simple apology:

I am sorry I must stop for now. I know it can be frustrating, but I don't feel right about asking any patients to wait too long beyond scheduled appointment times.

The patient may also have further objections that can be handled within empathic comments:

I know it can be frustrating to make a copayment for every visit, but sometimes there's just more than we can manage in any one time slot.

Summary

Setting the agenda at the beginning of the visit reduces last-minute additions by the patient. Sharing responsibility for agenda setting allows the patient to feel respected as a participant in that process. Shared responsibility does not end with the agenda but continues throughout the interaction. We can continue to check back with our patient to see if we are in agreement about the agenda, about the details of the history, about the patient's feelings and values, and about our final plans (15).

If we successfully agree with our patient on a full agenda, we may find that we no longer experience troublesome syndromes like "Oh, by the way, Doctor," the "positive review of systems," the "hidden agenda," and "my doctor doesn't understand me." Nor will we continue to blame our patients for a defective interview process. These accomplishments should lead to improvement in satisfaction for both doctor and patient.

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