of the nonantibiotic management occurred in three of the nine participating countries?

The value of international studies is illustrated precisely by these unanswered questions. Despite this need for further study, in the United States our belief that antibiotics are useful in acute otitis media management is so certain that to get any proposal for a placebo-controlled trial of antibiotics in patients with acute otitis media approved by an institutional review board would be nearly impossible. Differences in treatment effect for acute otitis media (and, of course, for many other conditions) will probably have to be investigated across national boundaries for two reasons: the first is that significant deviation from a standard treatment ("known" to be efficacious) for research purposes might not be possible within this country. The second reason is that we might not even think of certain diagnostic or management options, used in other countries, that are worthy of controlled examination. The catchment of other diagnostic and management options would be further enhanced by involving non-Western countries in any further expansion of the International Primary Care Network.

As illustrated in the article by Bartelds, et al., the methodological problems involved in conducting transnational studies are great and indeed suggest studies of their own. Does the complaint of ear pain mean the same thing in Switzerland as it does in the Netherlands? Does a red tympanic membrane mean the same thing in Belgium as it does in the United States or Israel? What in the various countries determines whether patients return for follow-up?

We must not be put off by these problems because of the important heuristic value of these studies. They have great potential for expanding the range of potentially researchable questions and developing additional useful methodologies. As we develop better skills for controlling variables (e.g., entry criteria), for defining management and outcome, and for improving follow-up, we will begin to answer — as well as ask — questions, and the answers will greatly affect the way we deal with common and important problems. We will be seeing more studies from both domestic and international networks addressing such common problems as back pain, asthma, bronchitis, and coronary artery disease. As we develop more sophisticated methods for primary care research and the necessary funding sources and expertise that allow us to conduct controlled trials and observational studies, we will see increasingly valuable clinical information emerging from these international efforts.

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Answers In Search Of Questions

There is a sense in which practicing comprehensive care resembles being a contestant on the television game show, "Jeopardy." Winning requires asking correct questions in response to given answers. Stakes and risks rise the longer the game is played until final jeopardy, when contestants must make a clever wager on their ability to state the appropriate question after a topic is announced, but before the answer has been given.

The game show analogy loses simplicity and precision in real-life family practice, but our capacity and willingness to ask revealing ques-

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tions often furnish the payoff in health screening and detecting hidden clinical problems. Through modern epidemiology we know in advance generic answers about what to expect: too many of our patients have not been screened properly for cancers, some have not been immunized adequately, some have unhealthy lifestyles and habits, some live under miserable social conditions, some have mental disorders, and many are at risk for degenerative conditions and infectious diseases.

Moreover, we also know that many patients with such conditions slip through our offices undetected. It is disappointing and distressing to read a growing number of research studies in our own journals showing that family physicians do not comply well with official recommendations for comprehensive care and are not particularly adept at recognizing mental disorders, substance abuse, sexual disorders, family violence, child abuse, and psychosocial factors in illnesses. It appears that we manifest, in our practices, some of the same behaviors we deplore in our patients — noncompliance, neglect, failure to follow through, and somatic preoccupation.

Reasons for these errors of omission are complex and include lack of time, inappropriate reimbursement, disagreement with recommendations, patient resistance, and costs of diagnostic and therapeutic procedures. Undoubtedly, there is a grain or two of truth in these and other reasons, but on the whole family physicians agree with authoritative recommendations and the epidemiological and cost-benefit data that undergird them. Studies also show that compliance and diagnostic accuracy can be improved, at least in the short run, by means of targeted education, reminder systems, and nurse monitoring of office routines; but improvement is modest and more is needed.

Part of the solution to this problem is low-tech and consists of seeking and creating opportunities for asking the questions that have taken on special contemporary importance. While interviewing skills are low-tech, they are not necessarily simple or easy, and my bias is that they ought not be delegated or reduced to a printed questionnaire, although the latter has its uses. A modern case history that makes any claim for comprehensiveness ought to include whatever can be learned about the following areas:

- Screening tests and attitudes toward screening
- Psychosocial stressors
- Mental disorders
- Habits
- Sexuality
- Victimization, violence, and abuse

The challenge is to design questions about these categories that fit one's personal style; questions not unduly intrusive or nonsequitur, invitational but not demanding or intimidating. The problem is that often these categories are not topics in the chief complaint or stated reason for the visit but must be discovered in the course of a clinical relationship that feels safe and supportive. Nevertheless, they comprise an agenda close to the surface of awareness, always alert for clues and opportunities. Insofar as they are able, family physicians should cultivate their capacities to overcome presumption, bias, resistance, and denial in coming to know their patients' clinically relevant characteristics, not alone for epidemiological accuracy but mostly for therapeutic effectiveness.

At the risk of pretentiousness, but without any claim for originality, I offer the following questions that family physicians might use in the interests of exploratory interviewing of the type being discussed. They represent a selective repertoire more than a protocol, but I know them to be usefully evocative, often opening up a topic in ways impossible to guess in advance. Others undoubtedly will have discovered better questions, and I hope they will find ways to make them available, perhaps through letters to the editor in response to this essay. There may be generational and training differences among family physicians as to style and content of interviewing, but the evidence is that, as a group, we do not do well enough when we have been studied.

How Are You Feeling?

There are golden moments near the beginnings of office visits that are loaded with possibilities for discovery if we do not channel the interview preemptively into details. The trick is to find the broadest, most open-ended and invitational question one can imagine, which will embrace not only chief complaints but also the sometimes complex gestational processes by which particular complaints came to be.

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Left to their own devices, medical students and residents seem unaccountably and irresistibly drawn to the patois of the salesperson for their opening gambits. "How can I help you?" or "What can I do for you?" are polite and somewhat invitational but also unimaginative and shopworn. They focus more attention on the putative helper than the helpee and sometimes elicit from thoughtful and carefully listening patients a plaintive, "Well, I don't know, but I hope you can do something." Then, with a wan smile, the interviewer has to regroup and find another opener.

Even so, such questions might be better than cruder, more direct assaults, such as, "What brings you to the office (clinic) today?" or "What seems to be the problem?" These have the virtue of inviting patients to think about themselves rather than the doctor and address the legitimate underlying agendum, which is "Why are you here today?" But they also contain a challenge to specify and justify the rationale for the visit that might squander the golden moment's possibilities.

Visiting a physician is an event in a person's life, a more or less decisive nodal point in experiences that have shadowy and ambiguous antecedents. One dreads what might be found and hopes that it turns out to be nothing of importance. Balint spoke of the time when the patient is alone with the illness, before it has even been identified surely as an illness — a time of rumination, testing, and cautious sharing with others who might offer a helpful perspective. Under these circumstances a brusque request to state the problem might seem premature unless the symptom is self-evidently concrete, such as an undeniable pain, a lump, or bleeding. Defining symptoms and giving them perspective often is the best outcome of a visit rather than its precondition.

Recently in courses about interviewing sponsored by academic general internists and their colleagues, "How are you feeling?" was proposed as an evocative opening question of appropriate breadth and open-endedness. When it is asked directly and quietly, giving the patient full attention and eye contact, it is transformed from a casual social exchange into a genuine clinical inquiry. A patient might choose to answer perfunctorily, but a pause or qualified answer is an opportunity for exploration that might be missed otherwise. Some physicians have testified that using this question changed their clinical work.

The internists also recommended following "How are you feeling?" with "Anything else?" repeated until the response is exhausted. Broyard, in his wonderful book, *Intoxicated by My Illness*, suggested that physicians ought to bleed their patients of talk. It seems to me that this is less an issue of enough time than of inclination. One does not have to hear everything at each visit, but surely there can be no quarrel about hearing it once.

Who Lives in Your Home?

This question can be the beginning of psychosocial inquiry because it reveals in a flash with whom the patient has daily intimate contact and care, if anyone. It requires no presumptions about marriage and significant others or the makeup of a family. The presence of an elderly parent, grandchildren, adult children, other relatives, friends, even boarders is clinically relevant. Moreover, this question often leads to an understanding of the living space, whether house, apartment, or mobile home, and its size, location, and apparent adequacy. I learned this question first from Dr. Lucy Candib, and it frequently produces surprisingly useful answers about current relationships and social conditions.

Have You Ever Been Treated for a Nervous or Mental Disorder?

Almost all functional mental disorders begin early in life, before the age of 40 years — usually earlier — and are recurrent. Not infrequently the best clue to a current illness is the history of previous treatment. The focus on treatment gives a clue to severity, namely, that the symptoms were regarded as important enough to need treating; and the fact of treatment seems easier to remember than the details of symptoms, which might have faded in memory. I am nonplused at times when patients say they had a nervous breakdown but can't remember the details of what actually happened. Moreover, there is a tendency to see each experience of illness as novel and a reluctance to associate it with what went before. This effort could be legitimate resistance to being labeled and a wish to be taken

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seriously, without presumption; but the truth is that a history of treatment for a mental disorder is important often in deciphering puzzling symptoms.

Eisenberg[1] recently summarized a good deal of evidence showing that there is a gap between knowledge and practice in recognizing and treating mental disorders, especially depression and anxiety, in primary care settings. Froom, et al.,[2] in a similar vein, established the performance characteristics of a single question in screening for major depressive disorder in a university family practice. The question, "Have you felt depressed or sad much of the time in the past year?" had a sensitivity of 95 percent, specificity of 79 percent, a positive predictive value of 41 percent, and a negative predictive value of 99 percent. Unfortunately, I cannot furnish such precise data about the other questions I am proposing, but it is gratifying to see demonstrated that a question can have research validity and reliability in leading to a criterion-based diagnosis.

Can You Tell Me about Your Habits?

This question is a gentle, permissive, nonaccusatory probe that has projective features. The patient decides what is meant and where to begin, which might give an indication of priority. It avoids a direct frontal assault on activities of which the patient is not proud and about which the patient might feel guilty. If the patient seems not to understand or hesitates in answering, it is easy to facilitate the reply by saying, "You know, coffee, tobacco, alcohol, drugs, foods?" By including several items in the list, the patient is invited to choose one that is less threatening to discuss first. Of course, the examiner's intent is to discuss each in appropriate detail. Once, in response to this question, a patient unexpectedly mentioned her chronic usage of diet pills, which I would have omitted. This generic question also puts the topic of habits into perspective within the case history and makes sense. It is easy to add to the list, at an opportune time, "What about your sexual habits?" — if this question is not included elsewhere, such as during the genitourinary system review or while performing the pelvic or genital examination.

Are You Satisfied with Your Sex Life?

While the HIV-infection epidemic brings a new sense of urgency to questions about sexual behavior in the practice of comprehensive care, it is by no means the only reason for concern. Other sexually transmitted diseases, sexual dysfunction — either primary or from other chronic diseases and drug treatment — contraception, unhappy relationships, behavioral problems, and mysterious psychosomatic symptoms all testify to the clinical importance of including sexuality in ordinary medical care. One could construct a reasonably accurate personality profile from sexual information, but the same can be said about one's attitudes toward and use of money or time (all three are inhibited topics). It is easier to talk about sex when it is a presenting complaint than to bring it up in a health maintenance examination.

A question about satisfaction with one's sex life seems gentle, humane, and nonjudgmental — and it fits the medical model. It does not presume anything, is permissive, and signals the physician's willingness to go further. It is easy to ask when one is doing the genital examination, and even if the answer is reassuring, it can be followed by, "Does that mean that everything is working the way it's supposed to?" Increasingly, I have been adding, "Do you have any reason to believe that you have any special risk for AIDS or HIV infection?" If the patient is noncommittal or puzzled by that, I have a chance to say what those risks might be.

Not long ago, I met a man in the office who complained of a chronic sore throat and an enlarged lymph node in his neck, neither of which I could confirm by examination. Finally, in response to "Is there anything you fear this might be?" he nervously related his anguish about the possible consequences of oral sex during an extramarital affair 6 years before. It is unlikely that I was able to exorcise his obsession in a single office visit, but I believe that the problem was exposed better than had I simply prescribed an antibiotic, which was what he said he needed.

Have You Ever Been Mistreated or Abused?

Evidence continues to mount that physical and sexual violence against persons by family members and other intimates has become an enormous clinical problem that crosses all boundaries of age, sex, race, and social class. It can have devastating consequences for mental and physi-

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cal health, not the least of which is repeating patterns of abuse. More victims than we are likely to imagine populate our practices in the form of unexplained trauma, depression, somatic complaints, marital problems, child-rearing problems, personality disorders, and drug and alcohol abuse. Physicians must find ways to initiate conversations that facilitate the discovery of abuse and follow through with treatment or referral.

The proposed question is only an opener, indicating awareness and willingness to talk about the problem. Intimidated victims might deny at first, but the door can be left ajar. It is a challenge to judge when merely to be receptive versus when to be aggressive in the face of imminent danger to the patient.

What Preventive Check-ups Have You Had?

Patients tend to be more willing to have preventive care than physicians think. It is more a matter of discipline and an appropriate record system than persuasion to get compliance with current recommendations for cancer screening, immunizations, and other preventive services. It is enough for this essay to remind us that health maintenance is a major priority to which we have not paid enough attention.

Conclusion

The stimulus for this essay is the increasing awareness that family physicians, when studied, do not perform as well as they might in addressing certain important clinical problems in which we claim to have both interest and skill. I find this inconsistency between rhetoric and practice troublesome and wonder what can be done to remedy it. Reflection suggests that the remedy is not technological or regulatory. There are no laboratory tests for the diagnosis of depression or any way to force it. It is discovered by interviewing or not at all. So, too, with other items that depend upon the case history. Unless and until we are replaced by automated questionnaires, we would do well to revisit our interviewing skills, reassess our commitment to comprehensive care, and adapt our data collection and management to the demands of modern epidemiology. I do not imagine that mindless interviewing protocols are called for, or that the questions I have proposed grow out of a Divine revelation. There must be dozens or scores of questions as good as or better than mine. Let us hear about them! Nothing defines the work of family physicians better than the range of topics we are prepared to inquire about with sensitivity and skill.

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