CHAPTER ORGANIZATION

The following color bars are used consistently for each section within a chapter to help locate specific information.

STRUCTURE AND FUNCTION

Anatomy and physiology by body system

SUBJECTIVE DATA

Health history through questions (examiner asks) and explanation (rationale)

OBJECTIVE DATA

Core of the examination part of each body system chapter with skills, expected findings, and common variations for healthy people, as well as selected abnormal findings

HEALTH PROMOTION AND PATIENT TEACHING

Health promotion related to each body system.

DOCUMENTATION AND CRITICAL THINKING

Clinical case studies with sample documentation for subjective, objective, and assessment data

ABNORMAL FINDINGS

Tables of art and photographs of pathologic disorders and conditions; abnormal findings for clinical practice and advanced practice where appropriate

CONTENTS

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Physical Examination & Health Assessment

Physical Examination & Health Assessment

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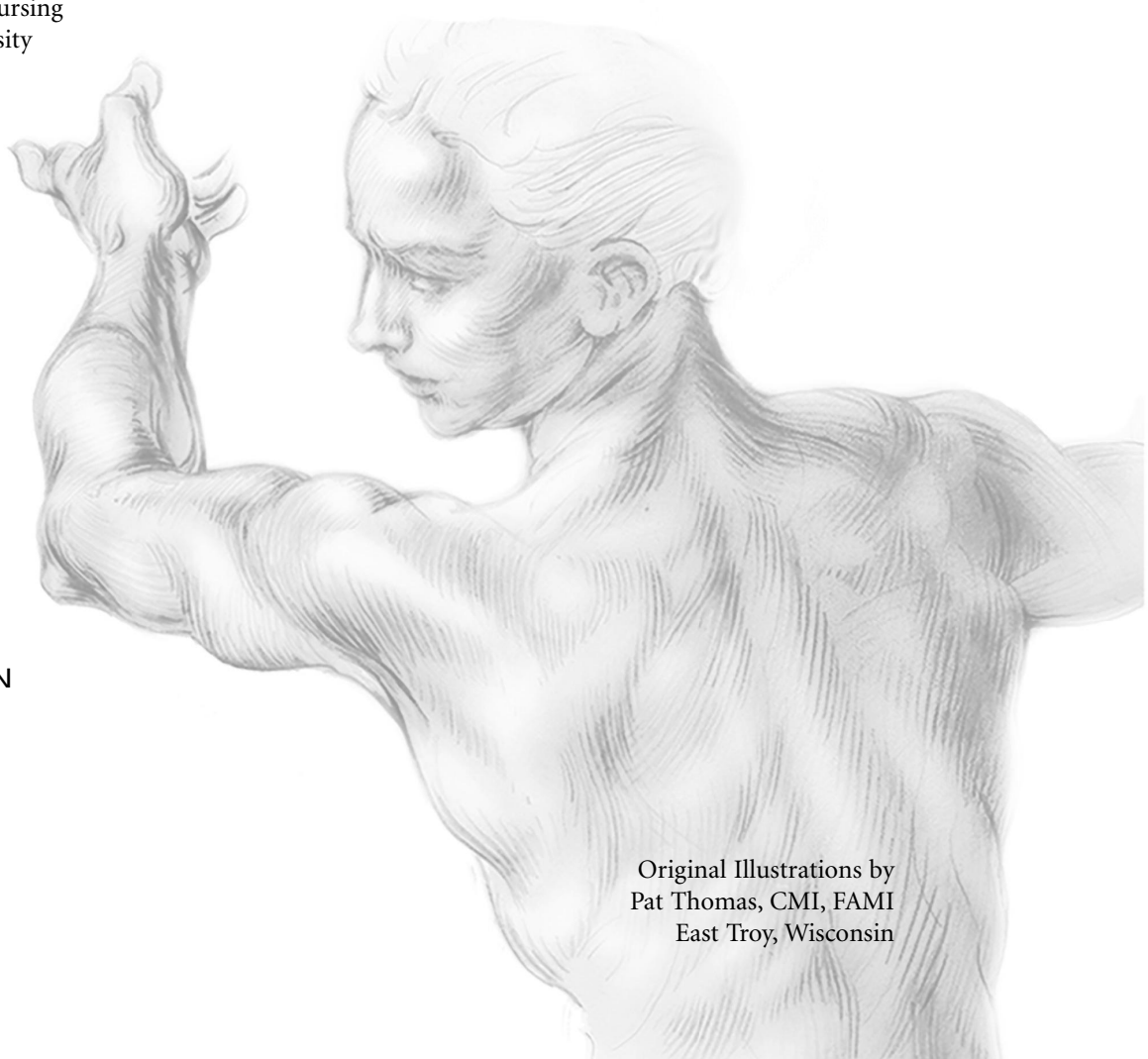

8TH EDITION

ELSEVIER

Original Illustrations by
Pat Thomas, CMI, FAMI
East Troy, Wisconsin

PHYSICAL EXAMINATION AND HEALTH ASSESSMENT, EIGHTH EDITION ISBN: 978-0-323-51080-6

International Standard Book Number: 978-0-323-51080-6

Executive Content Strategist: Lee Henderson
Senior Content Development Specialist: Heather Bays
Publishing Services Manager: Julie Eddy
Senior Project Manager: Jodi M. Willard
Design Direction: Brian Salisbury

Printed in Canada

Last digit is the print number: 9 8 7 6 5 4 3 2 1

ELSEVIER

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St. Louis, Missouri 63043

To Paul, with love and thanks. You have read every word.

ABOUT THE AUTHOR

Carolyn Jarvis received her PhD from the University of Illinois at Chicago, with a research interest in the physiologic effect of alcohol on the cardiovascular system; her MSN from Loyola University (Chicago); and her BSN cum laude from the University of Iowa. She is Professor, School of Nursing at Illinois Wesleyan University, where she teaches Health Assessment, Pathophysiology, and Pharmacology. Dr. Jarvis has taught physical assessment and critical care nursing at Rush University (Chicago), the University of Missouri (Columbia), and the University of Illinois (Urbana). Her current research interest concerns alcohol-interactive medications, and she includes Honors students in this research.

In 2016, Illinois Wesleyan University honored Dr. Jarvis for her contributions to the ever-changing field of nursing with the dedication of the Jarvis Center for Nursing Excellence. The Jarvis Center for Nursing Excellence equips students with laboratory and simulation learning so that they may pursue their nursing career with the same commitment as Dr. Jarvis.

Dr. Jarvis is the Student Senate Professor of the Year (2017) and was honored to give remarks at commencement. She is a recipient of the University of Missouri's Superior Teaching Award; has taught physical assessment to thousands of baccalaureate students, graduate students, and nursing professionals; has held 150 continuing education seminars; and is the author of numerous articles and textbook contributions.

Dr. Jarvis has maintained a clinical practice in advanced practice roles—first as a cardiovascular clinical specialist in various critical care settings and as a certified family nurse practitioner in primary care. During the last 12 years, her enthusiasm has focused on Spanish language skills to provide health care in rural Guatemala and at the Community Health Care Clinic in Bloomington. Dr. Jarvis has been instrumental in developing a synchronous teaching program for Illinois Wesleyan students both in Barcelona, Spain, and at the home campus.

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PREFACE

This book is for those who still carefully examine their patients and for those of you who wish to learn how to do so. You develop and practice, and then learn to trust, your health history and physical examination skills. In this book, we give you the tools to do that. Learn to listen to the patient—most often he or she will tell you what is wrong (and right) and what you can do to meet his or her health care needs. Then learn to inspect, examine, and listen to the person's body. The data are all there and are accessible to you by using just a few extra tools. High-tech machinery is a smart and sophisticated adjunct, but it cannot replace your own bedside assessment of your patient. Whether you are a beginning examiner or an advanced-practice student, this book holds the content you need to develop and refine your clinical skills.

This is a readable college text. All 8 editions have had these strengths: a clear, approachable writing style; an attractive and user-friendly format; integrated developmental variations across the life span with age-specific content on the infant, child, adolescent, pregnant woman, and older adult; cultural competencies in both a separate chapter and throughout the book; hundreds of meticulously prepared full-color illustrations; sample documentation of normal and abnormal findings and 60 clinical case studies; integration of the complete health assessment in 2 photo essays at the end of the book, where all key steps of a complete head-to-toe examination of the adult, infant, and child are summarized; and a photo essay highlighting a condensed head-to-toe assessment for each daily segment of patient care.

NEW TO THE EIGHTH EDITION

The 8th edition has a new chapter section and several new content features. Cultural Assessment in Chapter 2 is rewritten to increase emphasis on cultural assessment, self-assessment, and a new section on spiritual assessment. The Interview in Chapter 3 has a new section on interprofessional communication; Mental Status Assessment in Chapter 5 now includes the Montreal Cognitive Assessment; Substance Use Assessment in Chapter 6 includes additional content on opioid/heroin epidemic and alcohol-interactive medications; Domestic and Family Violence Assessment in Chapter 7 includes all new photos, updates on the health effects of violence, added information on the health effects of violence, and additional content on child abuse and elder abuse. The former Vital Signs and Measurement chapter is now split into 2 chapters to increase readability; the Vital Signs chapter (Chapter 10) stands alone with updated information on blood pressure guidelines.

The Physical Examination chapters all have a new feature—Health Promotion and Patient Teaching—to give the reader current teaching guidelines. Many chapters have all new exam photos for a fresh and accurate look. The focus throughout is evidence-based practice. Examination techniques are explained and included (and in some cases, rejected) depending on current clinical **evidence.**

Pat Thomas has designed 15 new art pieces in beautiful detail and 30 photo overlays. We have worked together to design new chapter openers and anatomy; note Fig. 11.4 on opioid targets, Figs. 14.1 and 14.2 on complex anatomy of skull and facial muscles, Fig. 15.5 on complex eye anatomy; Fig 23.8 on 3 images of complex shoulder anatomy showing muscle girdle, Fig. 27.2 on complex female internal anatomy, and many others. We have worked with Chandi Kesler and Kevin Strandberg in new photo shoots, replacing exam photos in Chapters 6 (Substance Use Assessment), 23 (Musculoskeletal System), 24 (Neurologic System), 28 (The Complete Health Assessment: Adult), and many others.

All physical examination chapters are **revised and updated,** with evidence-based data in anatomy and physiology, physical examination, and assessment tools. **Developmental Competence** sections provide updated common illnesses, growth and development information, and the Examination section of each body system chapter details **exam techniques and clinical findings for infants, children, adolescents, and older adults**.

Culture and Genetics data have been revised and updated in each chapter. Common illnesses affecting diverse groups are detailed. We know that some groups suffer an undue burden of some diseases, not because of racial diversity *per se*, but because these groups are overrepresented in the uninsured/poverty ranks and lack access to quality health care.

The **Abnormal Findings** tables located at the end of the chapters are revised and updated with many new clinical photos. These are still divided into two sections. The Abnormal Findings tables present frequently encountered conditions that every clinician should recognize, and the Abnormal Findings for Advanced Practice tables isolate the detailed illustrated atlas of conditions encountered in advanced practice roles.

Chapter references are up-to-date and are meant to be used. They include the best of clinical practice readings as well as basic science research and nursing research, with an emphasis on scholarship from the last 5 years.

DUAL FOCUS AS TEXT AND REFERENCE

Physical Examination & Health Assessment is a **text for beginning students** of physical examination as well as a **text and reference for advanced practitioners.** The chapter progression and format permit this scope without sacrificing one use for the other.

Chapters 1 through 7 focus on **health assessment of the whole person,** including health promotion for all age-groups, cultural environment and assessment, interviewing and complete health history gathering, the social environment of

mental status, and the changes to the whole person on the occasions of substance use or domestic violence.

Chapters 8 through 12 begin the approach to the **clinical care setting,** describing physical data-gathering techniques, how to set up the examination site, body measurement and vital signs, pain assessment, and nutritional assessment.

Chapters 13 through 27 focus on the **physical examination and related health history** in a body systems approach. This is the most efficient method of performing the examination and is the most logical method for student learning and retrieval of data. Both the novice and the advanced practitioner can review anatomy and physiology; learn the skills, expected findings, and common variations for generally healthy people; and study a comprehensive atlas of abnormal findings.

Chapters 28 through 32 **integrate the complete health assessment.** Chapters 28, 29 and 30 present the choreography of the head-to-toe exam for a complete screening examination in various age-groups and for the focused exam in this **unique chapter on a hospitalized adult**. Chapters 31 and 32 present special populations—the assessment of the pregnant woman and the functional assessment of the older adult, including assessment tools and caregiver and environmental assessment.

This text is valuable to both advanced practice students and experienced clinicians because of its comprehensive approach. *Physical Examination & Health Assessment* can help clinicians learn the skills for advanced practice, refresh their memory, review a specific examination technique when confronted with an unfamiliar clinical situation, compare and label a diagnostic finding, and study the Abnormal Findings for Advanced Practice.

CONTINUING FEATURES

1. **Method of examination** (Objective Data section) is clear, orderly, and easy to follow. Hundreds of original examination illustrations are placed directly with the text to demonstrate the physical examination in a step-by-step format.
2. **Two-column format** begins in the Subjective Data section, where the running column highlights the rationales for asking history questions. In the Objective Data section, the running column highlights selected abnormal findings to show a clear relationship between normal and abnormal findings.
3. **Abnormal Findings tables** organize and expand on material in the examination section. The **atlas** format of these extensive collections of pathology and original illustrations helps students recognize, sort, and describe abnormal findings.
4. **Genetics and cultural variations** in disease incidence and response to treatment are cited throughout using current evidence. The Jarvis text has the richest amount of cultural-genetic content available in any assessment text.
5. **Developmental approach** in each chapter presents a prototype for the adult, then age-specific content for the infant, child, adolescent, pregnant female, and older adult so students can learn common variations for all age-groups.
6. **Stunning full-color art** shows detailed human anatomy, physiology, examination techniques, and abnormal findings.
7. **Health history** (Subjective Data) appears in two places: (1) in Chapter 4, The Complete Health History; and (2) in pertinent history questions that are repeated and expanded in each regional examination chapter, including history questions that highlight health promotion and self-care. This presentation helps students understand the relationship between subjective and objective data. Considering the history and examination data together, as you do in the clinical setting, means that each chapter can stand on its own if a person has a specific problem related to that body system.
8. Chapter 3, The Interview, has the most complete discussion available on the process of communication, interviewing skills, techniques and traps, and cultural considerations (for example, how nonverbal behavior varies cross-culturally and the use of an interpreter).
9. **Summary checklists** at the end of each chapter provide a quick review of examination steps to help develop a mental checklist.
10. **Sample recordings** of normal and abnormal findings show the written language you should use so that documentation, whether written or electronic, is complete yet succinct.
11. **60 Clinical Case Studies** of frequently encountered situations that show the application of assessment techniques to patients of varying ages and clinical situations. These case histories, in SOAP format ending in diagnosis, use the actual language of recording. We encourage professors and students to use these as critical thinking exercises to discuss and develop a Plan for each one.
11. **User-friendly design** makes the book easy to use. Frequent subheadings and instructional headings assist in easy retrieval of material.
12. **Spanish-language translations** highlight important phrases for communication during the physical examination and appear on the inside back cover.

SUPPLEMENTS

- The ***Pocket Companion for Physical Examination & Health Assessment*** continues to be a handy and current clinical reference that provides pertinent material in full color, with over 200 illustrations from the textbook.
- The ***Study Guide & Laboratory Manual*** with physical examination forms is a full-color workbook that includes for each chapter a student study guide, glossary of key terms, clinical objectives, regional write-up forms, and review questions. The pages are perforated so students can use the regional write-up forms in the skills laboratory or in the clinical setting and turn them in to the instructor.

- The revised ***Health Assessment Online*** is an innovative and dynamic teaching and learning tool with more than **8000 electronic assets**, including video clips, anatomic overlays, animations, audio clips, interactive exercises, laboratory/diagnostic tests, review questions, and **electronic charting activities**. Comprehensive **Self-Paced Learning Modules** offer increased flexibility to faculty who wish to provide students with tutorial learning modules and in-depth capstone case studies for each body system chapter in the text. The **Capstone Case Studies** include **Quality and Safety Challenge** activities. Additional **Advance Practice Case Studies** put the student in the exam room and test history-taking and documentation skills. The comprehensive **video clip library** shows exam procedures across the life span, including clips on the pregnant woman. Animations, sounds, images, interactive activities, and video clips are embedded in the learning modules and cases to provide a dynamic, multimodal learning environment for today's learners.
- The companion ***EVOLVE Website*** (http://evolve.elsevier.com/Jarvis/) for students and instructors contains learning objectives, more than 300 multiple-choice and alternate-format review questions, printable key points from the chapter, and a comprehensive physical exam form for the adult. **Case studies**—including a variety of developmental and cultural variables—help students apply health assessment skills and knowledge. These include 25 in-depth case studies with critical thinking questions and answer guidelines. Also included is a complete Head-to-Toe Video Examination of the Adult that can be viewed in its entirety or by systems.
- ***Simulation Learning System.*** The new *Simulation Learning System* (SLS) is an online toolkit that incorporates medium- to high-fidelity simulation with scenarios that enhance the clinical decision-making skills of students. The SLS offers a comprehensive package of resources, including leveled patient scenarios, detailed instructions for preparation and implementation of the simulation experience, debriefing questions that encourage critical thinking, and learning resources to reinforce student comprehension.
- For instructors, the Evolve website presents TEACH for Nursing, PowerPoint slides, a comprehensive Image Collection, and a Test Bank. **TEACH for Nurses** provides annotated learning objectives, key terms, teaching strategies for the classroom in a revised section with strategies for both clinical and simulation lab use and a focus on QSEN competencies, critical thinking exercises, websites, and performance checklists. The **PowerPoint** slides include 2000 slides with integrated images and Audience Response Questions. A separate 1200-illustration **Image Collection** is featured and, finally, the ExamView **Test Bank** has over 1000 multiple-choice and alternate-format questions with coded answers and rationales.

IN CONCLUSION

Throughout all stages of manuscript preparation and production, we make every effort to develop a book that is readable, informative, instructive, and vital. Thank you for your enthusiastic response to the earlier editions of *Physical Examination & Health Assessment*. I am grateful for your encouragement and for your suggestions, which are incorporated wherever possible. Your comments and suggestions continue to be welcome for this edition.

Carolyn Jarvis
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ACKNOWLEDGMENTS

These 8 editions have been a labor of love and scholarship. During the 38 years of writing these texts, I have been buoyed by the many talented and dedicated colleagues who helped make the revisions possible.

Thank you to the bright, hardworking professional team at Elsevier. I am fortunate to have the support of Lee Henderson, Executive Content Strategist. Lee coordinates communication with Marketing and Sales and helps integrate user comments into the overall plan. I am grateful to work daily with Heather Bays, Senior Content Development Specialist. Heather juggled all the deadlines, readied all the manuscript for production, searched out endless photos for abnormal examination findings, kept current with the permissions, and so many other daily details. Her work is pivotal to our success. Heather, you rock.

I had a wonderful production team and I am most grateful to them. Julie Eddy, Publishing Services Manager, supervised the schedule for book production. I am especially grateful to Jodi Willard, Senior Project Manager, who has been in daily contact to keep the production organized and moving. She works in so many extra ways to keep production on schedule. I am pleased with the striking colors of the interior design of the 8th edition and the beautiful cover; both are the work of Brian Salisbury, Book Designer. The individual page layout is the wonderful work of Leslie Foster, Illustrator/Designer. Leslie hand-crafted every page, always planning how the page can be made better. Because of her work, we added scores of new art and content, and we still came out with comparable page length for the 8th edition.

I am so happy and excited to welcome Dr. Ann Eckhardt to this 8th edition. Ann has revised numerous chapters in this edition and is gifted with new ideas. I hope her contributions continue and grow. It has been wonderful to have a budding partner down the hall to bounce ideas and share chapter ideas and photo shoots.

I have gifted artistic colleagues, who made this book such a vibrant teaching display. Pat Thomas, Medical Illustrator, is so talented and contributes format ideas as well as brilliant drawings. Pat and I have worked together from the inception of this text. While we cannot answer each other's sentences, we have every other quality of a superb professional partnership. Chandi Kesler and Kevin Strandberg patiently set up equipment for all our photo shoots and then captured vivid, lively exam photos of children and adults. Julia Jarvis and Sarah Jarvis also photographed our infant photos with patience and clarity.

I am fortunate to have dedicated research assistants. Ani Almeroth searched and retrieved countless articles and sources. She was always prompt and accurate and anticipated my every request. Nicole Bukowski joined as a second research assistant and has been helpful in many ways. I am most grateful to Paul Jarvis, who read and reread endless copies of galley and page proof, finding any errors and making helpful suggestions.

Thank you to the faculty and students who took the time to write letters of suggestions and encouragement—your comments are gratefully received and are very helpful. I am fortunate to have the skilled reviewers who spend time reading the chapter manuscript and making valuable suggestions.

Most important are the members of my wonderful family, growing in number and in support. You all are creative and full of boundless energy. Your constant encouragement has kept me going throughout this process.

Carolyn Jarvis, PhD, APRN

CONTENTS

CHAPTER 1

Evidence-Based Assessment

http://evolve.elsevier.com/Jarvis/

1.1

C.D. is a 23-year-old Caucasian woman who works as a pediatric nurse at a children's hospital. She comes to clinic today for a scheduled physical examination to establish with a new primary care provider (Fig. 1.1). On arrival the examiner collects a health history and performs a complete physical examination. The preliminary list of significant findings looks like this:

- Recent graduate of a BSN program. Strong academic record (A/B). Reports no difficulties in college.

Past medical history:

- Diagnosed with type 1 diabetes at age 12 years. Became stuporous during a family vacation. Rushed home; admitted to ICU with decreased level of consciousness (LOC) and heavy labored breathing; blood sugar 1200 mg/dL. Coma × 3 days; ICU stay for 5 days. Diabetic teaching during hospital stay; follow-up with diabetic educator as needed.
- Now uses insulin pump. Reports HbA1c <7%.
- Finger fracture and ankle sprains during childhood (unable to remember exact dates).
- Bronchitis "a lot" as a child.
- Tympanostomy tubes at age 5 due to frequent ear infections. No issues in adulthood.
- Diabetic seizures at ages 16 and 18 caused by hypoglycemia. Family gave glucagon injection. Did not go to emergency department (ED).
- Denies tobacco use. Reports having 1 glass of red wine approximately 5-6 days in the past month.
- Current medications: Insulin, simvastatin, birth control pills, fish oil, multivitamin, melatonin (for sleep).
- Birth control since age 16 because of elevated blood sugar during menstruation. Annual gynecologic examinations started at age 21 years. Last Pap test 6 months ago; told was "negative."
- Family history: Mother and paternal grandfather with hypertension; maternal grandfather transient ischemic attack, died at age 80 from a myocardial infarction; maternal grandmother died at age 49 of cervical and ovarian cancer; paternal grandmother with arthritis in the hands and knees; paternal grandfather with kidney disease at age 76; sister with migraine headaches.
- BP 108/72 mm Hg right arm, sitting. HR 76 beats/min, regular. Resp 14/min unlabored.
- Weight 180 lbs. Height 5 ft 6 in. BMI 29 (overweight).
- Health promotion: Reports consistently wearing sunscreen when outside and completing skin self-examination every few months. Consistently monitors blood glucose. Walks 2 miles at least 3 days per week and does strength training exercises 2 days per week. No hypoglycemic episodes during exercise. Reports weekly pedicure and foot check to monitor for skin breakdown. Biannual dental visits. Performs breast self-examination monthly.
- Relationships: Close relationship with family (mother, father, brother, and sister); no significant other. Feels safe in home environment and reports having close female friends.
- Health perception: "Could probably lose some weight," but otherwise reports "good" health. Primarily concerned with blood sugar, which becomes labile with life transitions.
- Expectations of provider: Establish an open and honest relationship. Listen to her needs and facilitate her health goals.

Physical examination:

- Normocephalic. Face symmetric. Denies pain on sinus palpation.
- Vision tested annually. Has worn corrective lenses since 4th grade. PERRLA.

- Scarring of bilateral tympanic membranes. Denies hearing problems. Whispered words heard bilaterally.
- Gums pink; no apparent dental caries except for 3 noticeable fillings. Reports no dental pain.
- Compound nevus on left inner elbow; patient reports no recent changes in appearance. No other skin concerns.
- Breath sounds clear and equal bilaterally. Heart S_1S_2, neither accentuated nor diminished. No murmur or extra heart sounds.
- Clinical breast exam done with annual gynecologic visit.
- Abdomen is rounded. Bowel sounds present. Reports BM daily.
- Extremities warm and = bilat. All pulses present, 2+ and = bilat. No lymphadenopathy.
- Sensory modalities intact in legs and feet. No lesions.

The examiner analyzed and interpreted all the data; clustered the information, sorting out which data to refer and which to treat; and identified the diagnoses. It is interesting to note how many significant findings are derived from data the examiner collected. Not only physical data but also cognitive, psychosocial, and behavioral data are significant for an analysis of C.D.'s health state. The findings are interesting when considered from a life-cycle perspective; she is a young adult who predictably is occupied with the developmental tasks of emancipation from parents, building an independent lifestyle, establishing a vocation, making friends, forming an intimate bond with another, and establishing a social group. C.D. appears to be meeting the appropriate developmental tasks successfully.

A body of clinical **evidence** has validated the use of the particular assessment techniques in C.D.'s case. For example, measuring the BP screens for hypertension, and early intervention decreases the risk of heart attack and stroke. Monitoring blood sugar levels and HbA1c facilitates management of her type 1 diabetes. Completing a skin assessment reveals a nevus on her elbow that needs to be watched for any changes. Collecting health promotion data allows the examiner to personalize risk reduction and health promotion information while reinforcing positive behaviors already in place. The physical examination is not just a rote formality. Its parts are determined by the best clinical evidence available and published in the professional literature.

ASSESSMENT—POINT OF ENTRY IN AN ONGOING PROCESS

Assessment is the collection of data about the individual's health state. Throughout this text you will be studying the techniques of collecting and analyzing **subjective data** (i.e., what the person *says* about himself or herself during history taking) and **objective data** (i.e., what you as the health professional *observe* by inspecting, percussing, palpating, and auscultating during the physical examination). Together with the patient's record and laboratory studies, these elements form the **database**.

From the database you make a clinical judgment or diagnosis about the individual's health state, response to actual or potential health problems, and life processes. Thus the purpose of assessment is to make a judgment or diagnosis.

An organized assessment is the starting point of diagnostic reasoning. Because all health care diagnoses, decisions, and treatments are based on the data you gather during assessment, it is paramount that your assessment be factual and complete.

Diagnostic Reasoning

The step from data collection to diagnosis can be a difficult one. Most novice examiners perform well in gathering the data (given adequate practice) but then treat all the data as being equally important. This leads to slow and labored decision making.

Diagnostic reasoning is the process of analyzing health data and drawing conclusions to identify diagnoses. Novice examiners most often use a diagnostic process involving hypothesis forming and deductive reasoning. This hypothetico-deductive process has four major components: (1) attending to initially available cues; (2) formulating diagnostic hypotheses; (3) gathering data relative to the tentative hypotheses; and (4) evaluating each hypothesis with the new data collected, thus arriving at a final diagnosis. A *cue* is a piece of information, a sign or symptom, or a piece of laboratory or imaging data. A *hypothesis* is a tentative explanation for a cue or a set of cues that can be used as a basis for further investigation.

Once you complete data collection, develop a preliminary list of significant signs and symptoms for all patient health needs. This is less formal in structure than your final list of diagnoses will be and is in no particular order.

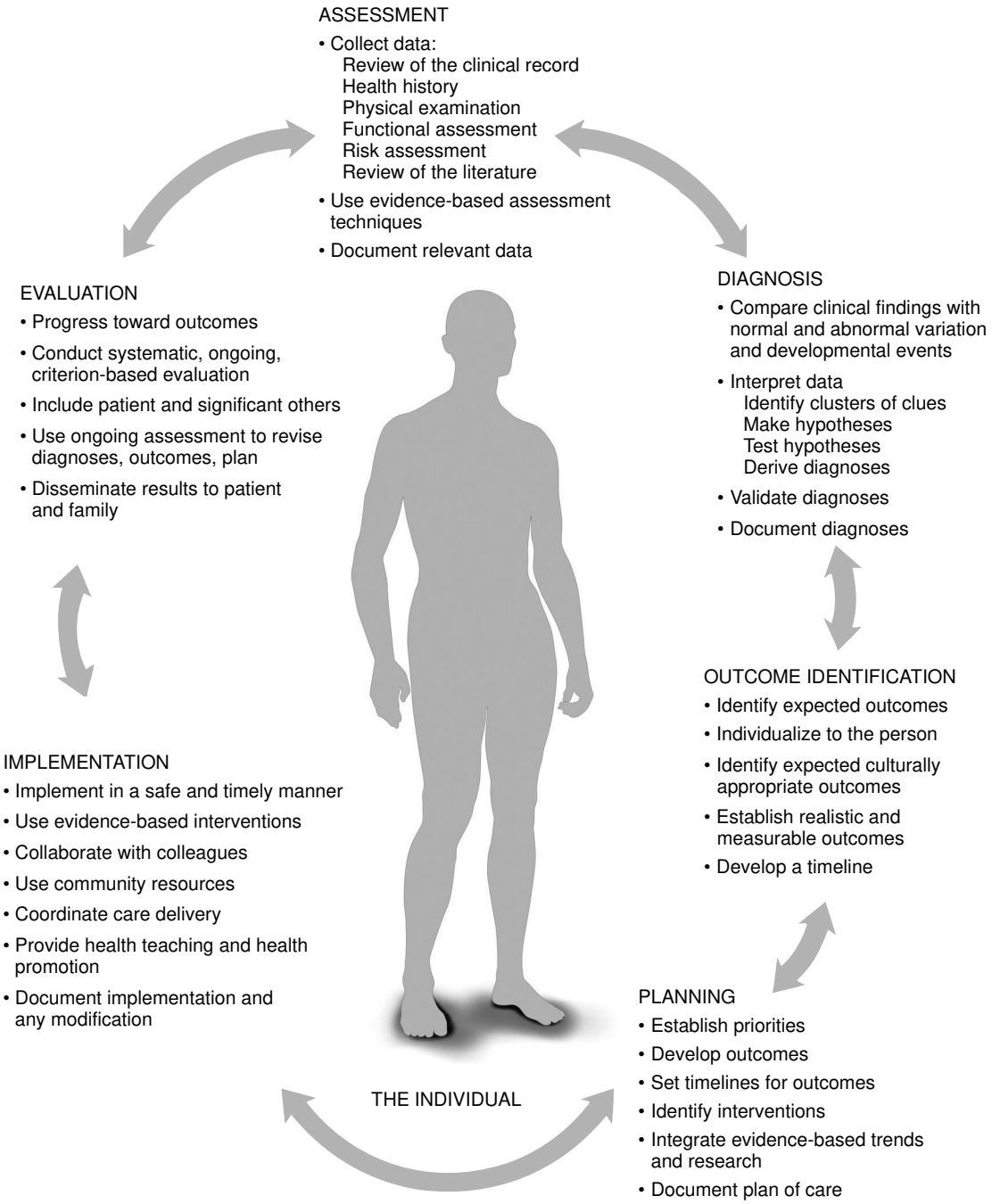
Cluster or group together the assessment data that appear to be causal or associated. For example, with a person in acute pain, associated data are rapid heart rate, increased BP, and anxiety. Organizing the data into meaningful clusters is slow at first; experienced examiners cluster data more rapidly because they recall proven results of earlier patient situations and recognize the same patterns in the new clinical situation.[14] What is often referred to as nurses' intuition is likely skilled pattern recognition by expert nurses.[13]

Validate the data you collect to make sure they are accurate. As you validate your information, look for gaps in data collection. Be sure to find the missing pieces, because identifying missing information is an essential critical-thinking skill. How you validate your data depends on experience. If you are unsure of the BP, validate it by repeating it yourself, or ask another nurse to validate the finding. Eliminate any extraneous variables that could influence BP results such as recent activity or anxiety over admission. If you have less experience analyzing breath sounds or heart murmurs, ask an expert to listen. Even with years of clinical experience, some signs always require validation (e.g., a breast lump).

Critical Thinking and the Diagnostic Process

The standards of practice in nursing, traditionally termed the **nursing process**, include six phases: assessment, diagnosis, outcome identification, planning, implementation, and evaluation.[3] This is an iterative process, allowing practitioners to move back and forth while caring for the needs of complex patients (Fig. 1.2).

Although the nursing process is a problem-solving approach, the way in which we apply the process depends on our level and years of experience. The *novice* has no experience with a specified patient population and uses rules to guide performance. It takes time, perhaps 2 to 3 years in similar clinical situations, to achieve *competency,* in which you see actions in the context of patient goals or plans of care. With more time and experience the *proficient* nurse understands a patient situation as a whole rather than as a list of tasks. At this level you can see long-term goals for the patient. You understand how today's interventions will help the patient in the future. Finally it seems that *expert* nurses vault over the steps and arrive at a clinical judgment in one leap. The expert has an intuitive grasp of a clinical situation and zeroes in on the accurate solution.[5,6]



1.2

(Alfaro-LeFevre, 2009.)

Functioning at the level of expert in clinical judgment includes using intuition. Intuition is characterized by immediate recognition of patterns; expert practitioners learn to attend to a pattern of assessment data and act without consciously labeling it. Whereas the beginner operates from a set of defined, structured rules, the expert practitioner uses intuitive links, has the ability to see salient issues in a patient situation, and knows instant therapeutic responses.[5,6] The expert has a storehouse of experience concerning which interventions have been successful in the past.

For example, compare the actions of the nonexpert and the expert nurse in the following situation of a young man with *Pneumocystis jiroveci* pneumonia:

> He was banging the side rails, making sounds, and pointing to his endotracheal tube. He was diaphoretic, gasping, and frantic. The nurse put her hand on his arm and tried to ascertain whether he had a sore throat from the tube. While she was away from the bedside retrieving an analgesic, the expert nurse strolled by, hesitated, listened, went to the man's bedside, reinflated the endotracheal cuff, and accepted the patient's look of gratitude because he was able to breathe again. The nonexpert nurse was distressed that she had misread the situation. The expert reviewed the signs of a leaky cuff with the nonexpert and pointed out that banging the side rails and panic help differentiate acute respiratory distress from pain.[12]

The method of moving from novice to becoming an expert practitioner is through the use of critical thinking. We all start as novices, when we need the familiarity of clear-cut rules to guide actions. Critical thinking is the means by which we learn to assess and modify, if indicated, before acting. We may even be beginners more than once during our careers. As we transition to different specialties, we must rebuild our database of experiences to become experts in new areas of practice.[1]

Critical thinking is required for sound diagnostic reasoning and clinical judgment. During your career you will need to sort through vast amounts of data to make sound judgments to manage patient care. These data will be dynamic, unpredictable, and ever changing. There will not be any one protocol you can memorize that will apply to every situation.

Critical thinking is recognized as an important component of nursing education at all levels.[2,21] Case studies and simulations frequently are used to encourage critical thinking with students. As a student, be prepared to think outside the box and think critically through patient-care situations. Critical thinking goes beyond knowing the pathophysiology of a disease process and requires you to put important assessment cues together to determine the most likely cause of a clinical problem and develop a solution. Critical thinking is a multidimensional thinking process, not a linear approach to problem solving.

Remember to approach problems in a nonjudgmental way and to avoid making assumptions. Identify which information you are taking for granted or information you may overlook based on natural assumptions. Rates of incorrect diagnoses are estimated to be as high as 10% to 15%, and one of the primary causes of misdiagnosis is the clinician's bias.[9] A 61-year-old man comes to your clinic with complaints of shortness of breath. His history reveals a 5-pound weight gain this week and a "fluttering in his chest." During the physical assessment you find 2+ pitting edema in bilateral lower extremities and an irregular apical pulse. Taken individually, ankle edema, weight gain, shortness of breath, and palpitations may appear unrelated, but together they are signs of an exacerbation of heart failure. Clustering of cues is extremely important in identifying a correct diagnosis. Another patient, an overweight 20-year-old female, comes to your office for a scheduled physical examination. Are you making assumptions about her lifestyle and eating habits? Make sure that you double-check the accuracy of your data (subjective and objective) and avoid assumptions that may bias your diagnosis.

Once you have clustered items that are related, you are ready to identify relevant information and anything that does not fit. In the case of your heart failure patient, his complaints

TABLE 1.1 Identifying Immediate Priorities

Principles of Setting Priorities

1. Complete a health history, including allergies, medications, current medical problems, and reason for visit.
2. Determine whether any problems are related, and set priorities. Priority setting evolves over time with changes in priority depending on the relationships between and severity of problems. For example, if the patient is having difficulty breathing because of acute rib pain, managing the pain may be a higher priority than dealing with a rapid pulse.

Steps to Setting Priorities

1. Assign high priority to **first-level** priority problems such as airway, breathing, and circulation.
2. Next attend to **second-level** priority problems, which include mental status changes, acute pain, infection risk, abnormal laboratory values, and elimination problems.
3. Address **third-level** priority problems such as lack of knowledge, mobility problems, and family coping.

Setting Priorities: Clinical Exemplar

You are working in the hospital and a patient is admitted to the emergency department with diabetic ketoacidosis as evidenced by a blood glucose of >1100 mg/dL. The patient is lethargic and cannot provide a history. Based on family report, he is 12 years old and has no significant medical, surgical, or medication history. Your first-level priorities include assuring a stable airway and adequate breathing. Your second-level priorities include addressing mental status changes and abnormal laboratory values by intervening to manage blood glucose levels. Once the patient has a stable blood sugar and is alert/oriented, you address third-level priorities, including diabetic education, nutritionist consults, and referral to community support groups as appropriate.

of a headache may be viewed as unrelated to the primary diagnosis, whereas abdominal pain and difficulty buttoning his pants are related (presence of ascites). As you gather clinical cues and complete an assessment, also think about priority setting (Table 1.1).

- **First-level priority problems** are those that are emergent, life threatening, and immediate, such as establishing an airway or supporting breathing.
- **Second-level priority problems** are those that are next in urgency—those requiring your prompt intervention to forestall further deterioration (e.g., mental status change, acute pain, acute urinary elimination problems, untreated medical problems, abnormal laboratory values, risks of infection, or risk to safety or security).
- **Third-level priority problems** are those that are important to the patient's health but can be attended to after more urgent health problems are addressed. Interventions to treat these problems are long term, and the response to treatment is expected to take more time. These problems may require a collaborative effort between the patient and health care professionals (Fig. 1.3).

Patients often require the assistance of an interdisciplinary team of practitioners to treat complex medical problems. Throughout your career, look for opportunities to work in collaborative teams and consult other practitioners as appropriate to care for your patients. Remember, health is complex and requires input from a variety of specialties (e.g., physical therapy, speech therapy, occupational therapy). Once you have determined problems, you must identify expected outcomes and work with the patient to facilitate outcome achievement. Remember, your outcomes need to be measurable. Set small goals that can be accomplished in a given time frame. For your heart failure patient your goal may be to eliminate supplemental oxygen needs before discharge.

1.3

Include your patient and his or her input, as appropriate, in your outcome identification. Patients are more likely to participate actively in care and follow through with recommendations if they are part of developing the plan of care.

The final steps to the critical-thinking process include evaluation and planning. You must continuously evaluate whether you are on the right track and correct any missteps or misinterpretation of data. If you are not on the right path, reassess, reanalyze, and revise. The final step is the development of a comprehensive plan that is kept up to date. Communicate the plan to the multidisciplinary team. Be aware that this is a legal document and that accurate recording is important for evaluation, insurance reimbursement, and research.

EVIDENCE-BASED ASSESSMENT

Does honey help burn wounds heal more quickly? Do mobile health technologies improve patient compliance with medication administration? Does male circumcision reduce the risk of transmitting human immunodeficiency virus (HIV) in heterosexual men? Can magnesium sulfate reduce cerebral palsy risk in premature infants? Is aromatherapy an effective treatment for postoperative nausea and vomiting?

Health care is a rapidly changing field. The amount of medical and nursing information available has skyrocketed. Current efforts of cost containment result in a hospital population composed of people who have a higher acuity but are discharged earlier than ever before. Clinical research studies are continuously pushing health care forward. Keeping up with these advances and translating them into practice are very challenging. Budget cuts, staff shortages, and increasing patient acuity mean that the clinician has little time to grab a lunch break, let alone browse the most recent journal articles for advances in a clinical specialty.

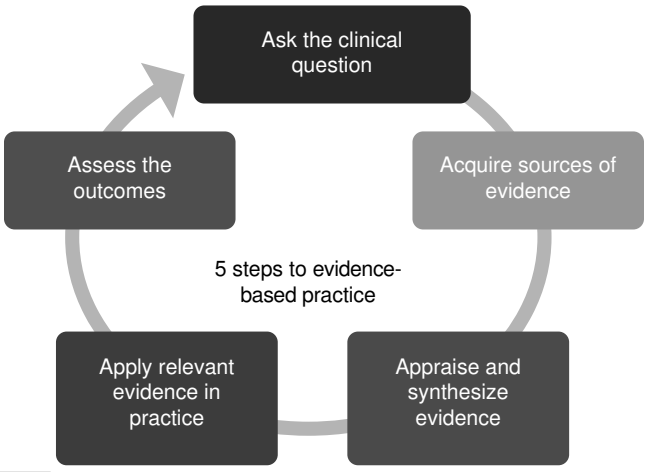
The conviction that all patients deserve to be treated with the most current and best-practice techniques led to the development of **evidence-based practice (EBP)**. As early as the 1850s Florence Nightingale was using research evidence to improve patient outcomes during the Crimean War. It was not until the 1970s, however, that the term *evidence-based medicine* was coined.[16] In 1972 a British epidemiologist and early proponent of EBP, Archie Cochrane, identified a pressing need for systematic reviews of randomized clinical trials. In a landmark case, Dr. Cochrane noted multiple clinical trials published between 1972 and 1981 showing that the use of corticosteroids to treat women in premature labor reduced the incidence of infant mortality. A short course of corticosteroid stimulates fetal lung development, thus preventing respiratory distress syndrome, a serious and common complication of premature birth. Yet these findings had not been implemented into daily practice, and thousands of low-birth-weight premature infants were dying needlessly. Following a systematic review of the evidence in 1989, obstetricians finally accepted the use of corticosteroid treatment as standard practice for women in preterm labor. Corticosteroid

treatment has since been shown to reduce the risk of infant mortality by 30% to 50%.[7]

EBP is more than the use of best-practice techniques to treat patients. The definition of EBP is multifaceted and reflects holistic practice. Once thought to be primarily clinical, EBP now encompasses the integration of research evidence, clinical expertise, clinical knowledge (physical assessment), and patient values and preferences.[16] Clinical decision making depends on all four factors: the best evidence from a critical review of research literature; the patient's own preferences; the clinician's own experience and expertise; and finally physical examination and assessment. Assessment skills must be practiced with hands-on experience and refined to a high level.

Although assessment skills are foundational to EBP, it is important to question tradition when no compelling research evidence exists to support it. Some time-honored assessment techniques have been removed from the examination repertoire because clinical evidence indicates that these techniques are not as accurate as once believed. For example, the traditional practice of auscultating bowel sounds was found to be a poor indicator of returning GI motility in patients having abdominal surgery.[17,18] Following the steps to EBP, the research team asked an evidence-based question (Fig. 1.4). Next, best research evidence was gathered through a literature search, which suggested that early postoperative bowel sounds probably do not represent return of normal GI motility. The evidence was appraised to identify whether a different treatment or assessment approach was better. Research showed the primary markers for returning GI motility after abdominal surgery to be the return of flatus and the first postoperative bowel movement. Based on the literature, a new practice protocol was instituted, and patient outcomes were monitored. Detrimental outcomes did not occur; the new practice guideline was shown to be safe for patients' recovery and a better allocation of staff time. The research led to a change of clinical practice that was safe, effective, and efficient.

Evidence shows that other assessment skills *are* effective for patient care. For example, clinicians should measure the ankle brachial index (ABI), as described in Chapter 21 of this text. Evidence is clear about the value of ABI as a screening measure for peripheral artery disease.



1.4 (Eckhardt, 2018.)

Despite the advantages to patients who receive care based on EBP, it often takes up to 17 years for research findings to be implemented into practice.[4] This troubling gap has led researchers to examine closely the barriers to EBP, both as individual practitioners and as organizations. As individuals, nurses lack research skills in evaluating quality of research studies, are isolated from other colleagues knowledgeable in research, and lack confidence to implement change. Other significant barriers are the organizational characteristics of health care settings. Nurses lack time to go to the library to read research; health care institutions have inadequate library research holdings; and organizational support for EBP is lacking when nurses wish to implement changes in patient care.[15]

Fostering a culture of EBP at the undergraduate and graduate levels is one way in which health care educators attempt to make evidence-based care the gold standard of practice. Students of medicine and nursing are taught how to filter through the wealth of scientific data and critique the findings. They are learning to discern which interventions would best serve their individual patients. Facilitating support for EBP at the organizational level includes time to go to the library; teaching staff to conduct electronic searches; journal club meetings; establishing nursing research committees; linking staff with university researchers; and ensuring that adequate research journals and preprocessed evidence resources are available in the library.[15] *"We have come to a time when the credibility of the health professions will be judged by which of its practices are based on the best and latest evidence from sound scientific studies in combination with clinical expertise, astute assessment, and respect for patient values and preferences."*[20]

COLLECTING FOUR TYPES OF PATIENT DATA

Every examiner needs to establish four different types of databases, depending on the clinical situation: complete, focused or problem-centered, follow-up, and emergency.

Complete (Total Health) Database

This includes a complete health history and a full physical examination. It describes the current and past health state and forms a baseline against which all future changes can be measured. It yields the first diagnoses.

The complete database often is collected in a primary care setting such as a pediatric or family practice clinic, independent or group private practice, college health service, women's health care agency, visiting nurse agency, or community health agency. When you work in these settings, you are the first health professional to see the patient and have primary responsibility for monitoring the person's health care. Collecting the complete database is an opportunity to build and strengthen your relationship with the patient. For the well person this database must describe the person's

health state; perception of health; strengths or assets such as health maintenance behaviors, individual coping patterns, support systems, and current developmental tasks; and any risk factors or lifestyle changes. For the ill person the database also includes a description of the person's health problems, perception of illness, and response to the problems.

For well and ill people, the complete database must screen for pathology and determine the ways people respond to that pathology or to any health problem. You must screen for pathology because you are the first, and often the only, health professional to see the patient. This screening is important to refer the patient to another professional, help the patient make decisions, and perform appropriate treatments. This database also notes the human responses to health problems. This factor is important because it provides additional information about the person that leads to nursing diagnoses.

In acute hospital care the complete database is gathered on admission to the hospital. In the hospital, data related specifically to pathology may be collected by the admitting physician. You collect additional information on the patient's perception of illness, functional ability or patterns of living, activities of daily living, health maintenance behaviors, response to health problems, coping patterns, interaction patterns, spiritual needs, and health goals.

Focused or Problem-Centered Database

This is for a limited or short-term problem. Here you collect a "mini" database, smaller in scope and more targeted than the complete database. It concerns mainly one problem, one cue complex, or one body system. It is used in all settings—hospital, primary care, or long-term care. For example, 2 days after surgery a hospitalized person suddenly has a congested cough, shortness of breath, and fatigue. The history and examination focus primarily on the respiratory and cardiovascular systems. Or in an outpatient clinic a person presents with a rash. The history follows the direction of this presenting concern such as whether the rash had an acute or chronic onset; was associated with a fever, new food, pet, or medicine; and was localized or generalized. Physical examination must include a clear description of the rash.

Follow-Up Database

The status of any identified problems should be evaluated at regular and appropriate intervals. What change has occurred? Is the problem getting better or worse? Which coping strategies are used? This type of database is used in all settings to follow up both short-term and chronic health problems. For example, a patient with heart failure may follow up with his or her primary care practitioner at regular intervals to reevaluate medications, identify changes in symptoms, and discuss coping strategies.

Emergency Database

This is an urgent, rapid collection of crucial information and often is compiled concurrently with lifesaving measures. Diagnosis must be swift and sure. For example, a person is brought into an ED with suspected substance overdose. The first history questions are "What did you take?" "How much did you take?" and "When?" The person is questioned simultaneously while his or her airway, breathing, circulation, level of consciousness, and disability are being assessed. Clearly the emergency database requires more rapid collection of data than the episodic database. Once the person has been stabilized, a complete database can be compiled. An emergency database may be compiled by questioning the patient, or if the patient is unresponsive, health care providers may need to rely on family and friends.

EXPANDING THE CONCEPT OF HEALTH

Assessment is the collection of data about a person's health state. A clear definition of health is important because this determines which assessment data should be collected. In general the list of data that must be collected has lengthened as our concept of health has broadened.

Consideration of the whole person is the essence of **holistic health.** Holistic health views the mind, body, and spirit as interdependent and functioning as a whole within the environment. Health depends on all these factors working together. The basis of disease is multifaceted, originating from both within the person and from the external environment. Thus the treatment of disease requires the services of numerous providers. Nursing includes many aspects of the holistic model (i.e., the interaction of the mind and body, the oneness and unity of the individual). Both the individual human and the external environment are open systems, dynamic and continually changing and adapting to one another. Each person is responsible for his or her own personal health state and is an active participant in health care. Health promotion and disease prevention form the core of nursing practice.

In a holistic model, assessment factors are expanded to include such things as lifestyle behaviors, culture and values, family and social roles, self-care behaviors, job-related stress, developmental tasks, and failures and frustrations of life. All are significant to health.

Health promotion and disease prevention now round out our concept of health. Guidelines to prevention emphasize the link between health and personal behavior. The report of the U.S. Preventive Services Task Force[23] asserts that the great majority of deaths among Americans younger than 65 years are preventable. Prevention can be achieved through counseling from primary care providers designed to change people's unhealthy behaviors related to smoking, alcohol and other drug use, lack of exercise, poor nutrition, injuries, and sexually transmitted infections.[10] Health promotion is a set of positive acts that we can take. In this model the focus of the health professional is on teaching and helping the consumer choose a healthier lifestyle.

The frequency interval of assessment varies with the person's illness and wellness needs. Most ill people seek care because of pain or some abnormal signs and symptoms they have noticed, which prompts an assessment (i.e., gathering a complete, a focused, or an emergency database). In addition,

1.5 (Yoder-Wise, 2015.)

risk assessment and preventive services can be delivered once the presenting concerns are addressed. Interdisciplinary collaboration is an integral part of patient care (Fig. 1.5). Providers, nurses, dietitians, therapists and other health professionals must work together to care for increasingly complex patients.

For the well person opinions are inconsistent about assessment intervals. The term *annual checkup* is vague. What does it constitute? Is it necessary or cost-effective? How can primary-care clinicians deliver services to people with no signs and symptoms of illness? Periodic health checkups are an excellent opportunity to deliver preventive services and update the complete database. Although periodic health checkups could induce unnecessary costs and promote services that are not recommended, advocates justify well-person visits because of delivery of some recommended preventive services and reduction of patient worry.[11,19]

The *Guide to Clinical Preventive Services* is a positive approach to health assessment and risk reduction.[23] The *Guide* is updated annually and is accessible online or in print. It presents evidence-based recommendations on screening, counseling, and preventive topics and includes clinical considerations for each topic. These services include screening factors to gather during the history, age-specific items for physical examination and laboratory procedures, counseling topics, and immunizations. This approach moves away from an annual physical ritual and toward varying periodicity based on factors specific to the patient. Health education and counseling are highlighted as the means to deliver health promotion and disease prevention.

For example, the guide to examination for C.D. (23-year-old female, nonpregnant, not sexually active) would recommend the following services for preventive health care:

1. **Screening history** for dietary intake, physical activity, tobacco/alcohol/drug use, and sexual practices
2. **Physical examination** for height and weight, BP, and screening for cervical cancer and HIV
3. **Counseling** for physical activity and risk prevention (e.g., secondhand smoke, seatbelt use)
4. **Depression** screening
5. **Healthy diet** counseling, including lipid disorder screening and obesity screening
6. **Chemoprophylaxis** to include multivitamin with folic acid (females capable of or planning pregnancy)

C.D. is living successfully with a serious chronic condition. Because she has diabetes, including periodic checks of hemoglobin A1c and a fasting glucose level are important. In addition, you should ask how her pump is functioning and whether she is having any difficulties with blood sugar control.

CULTURE AND GENETICS

In a holistic model of health care, assessment factors must include culture. An introduction to cross-cultural concepts follows in Chapter 2. These concepts are developed throughout the text as they relate to specific chapters.

Metaphors such as *melting pot, mosaic,* and *salad bowl* have been used to describe the cultural diversity that characterizes the United States. The United States is becoming a majority-minority nation. Although non-Hispanic whites will remain the largest single group, they will no longer constitute a numeric majority. *Emerging minority* is a term that has been used to classify the populations, including African Americans, Latinos, and Asian Americans, that are rapidly becoming a combined numeric majority.[22] By 2060 the U.S. Census Bureau projects that minorities will constitute 56% of the population. The Latino and Asian populations are projected to nearly double by 2060, and all other racial groups are expected to increase as well. By 2060 nearly 29% of the population will be Latino, 14% African American, 9% Asian, and just over 1% American Indians or Alaska Natives. In 2040 the U.S. Census Bureau anticipates that there will be more people over the age of 65 years than under the age of 18 years for the first time in history.[8]

The United States is becoming increasingly diverse, making cultural competence more important and more challenging for health care providers. U.S. health care providers also travel abroad to work in a variety of health care settings in the international community. Medical and nursing teams volunteer to provide free medical and surgical care in developing countries (Fig. 1.6). International interchanges are increasing among health care providers, making attention to the cultural aspects of health and illness an even greater priority.

During your professional career you may be expected to assess short-term foreign visitors who travel for treatments, international university faculty, students from abroad studying in U.S. high schools and universities, family members of foreign diplomats, immigrants, refugees, members of more than 106 different ethnic groups, and American Indians from 510 federally recognized tribes. A serious conceptual problem exists in that nurses and physicians are expected to know, understand, and meet the health needs of people from

1.6

culturally diverse backgrounds with minimal preparation in cultural competence.

Culture has been included in each chapter of this book. Understanding the basics of a variety of cultures is important in health assessment. People from varying cultures may interpret symptoms differently; therefore, asking the right questions is imperative for you to gather data that are accurate and meaningful. It is important to provide culturally relevant health care that incorporates cultural beliefs and practices. An increasing expectation exists among members of certain cultural groups that health care providers will respect their "cultural health rights," an expectation that may conflict with the unicultural Western biomedical worldview taught in U.S. educational programs that prepare nurses, doctors, and other health care providers.

Given the multicultural composition of the United States and the projected increase in the number of individuals from diverse cultural backgrounds anticipated in the future, a concern for the cultural beliefs and practices of people is increasingly important.

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CHAPTER 2

Cultural Assessment

http://evolve.elsevier.com/Jarvis/

2.1

As a health professional, it is imperative that you learn to build trusting relationships with patients. Part of forming trust is listening to each patient's individual needs and establishing an awareness of his or her culture. You must be open to people who are different from you, have a curiosity about people, and work to become culturally competent (Fig. 2.1). A cultural assessment is an integral part of forming a full database of information about each patient. Serious errors can occur due to lack of cultural competence. If you fail to ask about traditional, herbal, or folk remedies, you may unknowingly give or prescribe a medication that has a significant interaction. For example, ginseng raises the serum digoxin level and can lead to adverse, even fatal, consequences.[18]

A key to understanding cultural diversity is self-awareness and knowledge of one's own culture. Your cultural identification might include the subculture of nursing or health care professionals. You might identify yourself as a Midwesterner, a college student, an athlete, a member of the Polish community, or a Buddhist. These multiple and often changing cultural and subcultural identifications help define you and influence your beliefs about health and illness, coping mechanisms, and wellness behaviors. Developing self-awareness will make you a better health care provider and ensure that you are prepared to care for diverse clients. Recognizing your own culture, values, and beliefs is an interactive and ongoing process of self-discovery.[18] A cultural assessment of each patient is important, but a cultural self-assessment is also an integral component of becoming culturally competent. To understand another person's culture, you must first understand your own culture.

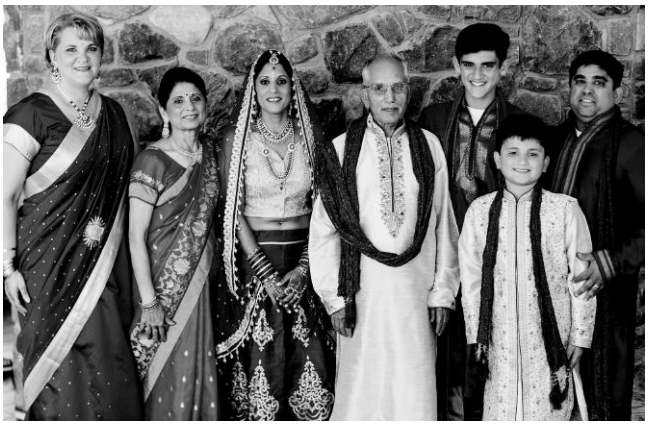
Over the course of your professional education, you will study physical examination and health promotion across the life span and learn to conduct numerous assessments such as a health history, a physical examination, a mental health assessment, a domestic violence assessment, a nutritional assessment, and a pain assessment. However, depending on the cultural and racial background of the person, the data you gather in the assessments may vary. Therefore a cultural assessment must be an integral component of a complete physical and health assessment.

DEMOGRAPHIC PROFILE OF THE UNITED STATES

The estimates of the U.S. population illustrate the increasing diversity in the population and highlight the importance of cultural competence in health care.[40] The population of the United States exceeded 321 million people in 2015 with only 61.6% of the population identifying as white, non-Hispanic.[38] Over 13% of the U.S. population were born elsewhere, and over 21% of the U.S. population report speaking a language other than English in the home.[3,37] The national minority, actually *emerging majority*, population makes up 38% of the total. Among this emerging majority, the largest ethnic group is Hispanic, who make up 17.6% of the population and are the fastest-growing minority group. The largest racial minority group is African American or black (13.3%), followed by Asians (5.6%), two or more races (2.6%), American Indians and Alaska natives (1.2%), and native Hawaiians and other Pacific Islanders (0.2%).[38]

There are demographic differences between the emerging majority groups when compared with non-Hispanic whites. These demographic differences include age, poverty level, and household composition. The number of relatives living in the household is higher for all racial and ethnic minorities compared to non-Hispanic whites, as is the number of multigenerational families (Fig. 2.2). African Americans, American Indians, and Alaska natives are more likely to have grandparents who are responsible for the care of grandchildren compared with other groups.[37]

Asians and non-Hispanic whites have the highest median income, whereas African Americans have the lowest household income followed by Hispanics. All ethnic and racial minority



2.2 (Courtesy Holly Birch Photography.)

groups have poverty rates exceeding the national average of 14.8%. Non-Hispanic whites have the lowest reported poverty at 10%, whereas 25.2% of African Americans and 24.7% of Hispanics live at or below the poverty line.[11] Contributing to the high rates of poverty is low educational attainment. Approximately 33% of Hispanics and 13% of African Americans have less than a high school education compared with 6.7% of non-Hispanic whites.[33] Lower educational levels and lower income levels are also correlated with likelihood of disability. Approximately 20% of adults report having a disability. African Americans were the most likely to report a disability (29%), followed by Hispanics (25.9%).[6]

IMMIGRATION

Immigrants are people who are not U.S. citizens at birth. Some new immigrants have minimal understanding of health care resources and how to navigate the health care system. They may not speak or understand English, and they may not be literate in the language of their country of origin. Therefore it is imperative that health care providers address the needs of this growing population.

In 2014 the population of the United States included over 42.2 million foreign-born individuals, which accounted for 13.2% of the population. The number of foreign-born individuals residing in the United States has quadrupled since the 1960s and is expected to almost double by 2065.[3] During your career, you will care for foreign-born individuals who have unique health care needs. The United States health care system is complex and difficult to navigate for anyone. Keep in mind, the health care system may be even more difficult for foreign-born individuals with limited English proficiency. Make sure that you identify interpreter needs early and ask the appropriate cultural assessment questions when caring for each patient.

DETERMINANTS OF HEALTH AND HEALTH DISPARITIES

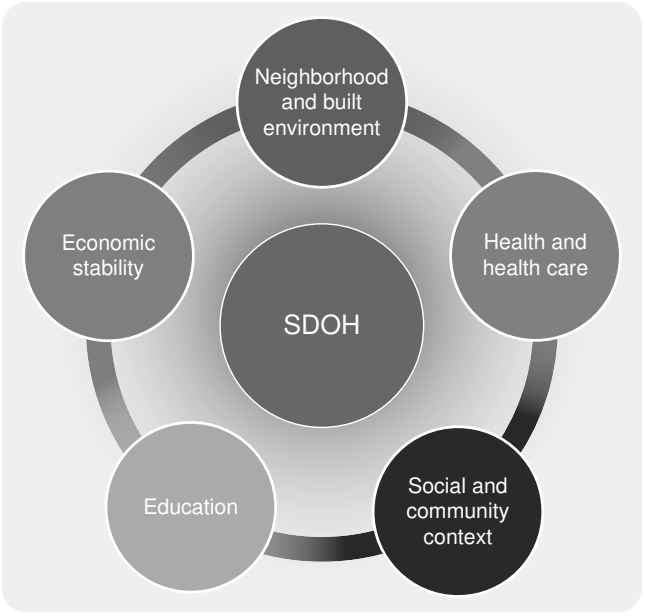
An individual's health status is influenced by a constellation of factors known as social determinants of health (SDOH).[15] The social determinants of health include economic stability, education, social and community context, neighborhood and built environment, and health and health care (Fig. 2.3). The five social determinants of health are interconnected and affect a person's health from preconception to death. However, evidenced-based research has consistently shown that poverty has the greatest influence on health status.

For the past two decades the goals of *Healthy People* have been to eliminate health disparities. A health disparity is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[12]

New health care delivery frameworks must strive for social and physical environments that promote quality of life free from preventable illness, disability, and premature death. Public health sectors must be encouraged to address the needs for safe and affordable housing; reliable transportation; nutritious food that is accessible to everyone; safe, well-integrated neighborhoods and schools; health care providers that are culturally and linguistically competent; and clean water and air.

Health Care Disparities Among Vulnerable Populations

Health disparities affect people who experience social, economic, and/or environmental disadvantage. These people are vulnerable populations and include ethnic and racial minorities, people with disabilities, and the LGBT community. Health care disparities are measured by comparing the percent of difference from one group to the best group rate for a disease. One study found a 33-year age difference



2.3 (USSDHS, 2018.)

between the longest- and shortest-living groups in the United States.[13] In another example, African American children are twice as likely to be hospitalized and four times as likely to die from asthma as non-Hispanic whites.[13] Overall infant mortality in the United States is 5.90 per 1,000 live births, but the mortality rate for African American infants is 10.93 per 1,000 live births.[27] Lack of health insurance may contribute to health disparities. An estimated 10.6% of non-Hispanic whites do not have health insurance, whereas more than 30% of Hispanics, nearly 19% of non-Hispanic blacks, and almost 14% of Asians lack basic insurance coverage.[7]

Few of the differences in health between ethnic and racial groups have a biologic basis but rather pertain to the social determinants of health. Disparities in exposure to environmental contaminants, violence, and substance abuse among some racial and ethnic minorities suggest the need for a major transformation of the neighborhoods and social contexts of people's lives. Although overall quality of health care is improving in the United States, access to care and health disparities are not showing any improvement.[14]

National Cultural and Linguistic Standards

Many forms of discrimination based on race or national origin limit the opportunities for people to gain equal access to health care services. Many health and social service programs provide information about their services in English only. Language barriers have a negative impact on the quality of care provided, and those patients with language barriers also have increased risk of noncompliance to treatment regimens.

Because immigration occurs at high levels and immigrants with limited English proficiency (LEP) have particular needs, the Office of Minority Health published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. This set of 15 standards provides a blueprint to improve quality of care and eliminate health disparities for culturally diverse populations. Health disparities affect the health of individuals and communities, making this a major public health concern in the United States.[39]

Linguistic Competence

Under the provisions of Title VI of the Civil Rights Act of 1964, when people with LEP seek health care in settings such as hospitals, nursing homes, clinics, daycare centers, and mental health centers, services cannot be denied to them. English is the predominant language of the United States. However, among people at least 5 years old living in the United States, 21% spoke a language other than English at home.[38] Of those, 62% spoke Spanish, 18% reported speaking an Indo-European language, 16% spoke an Asian language, and 4% spoke a different language. Of people who spoke a language other than English at home, nearly 42% reported that they did not speak English "very well."[38]

When people with LEP seek health care, they are frequently faced with receptionists, nurses, and physicians who speak English only. Additional time and resources are necessary to adequately care for patients with LEP. The language barrier may lead to a decreased quality of care due to limited understanding of patient needs. To prevent serious adverse health outcomes for LEP persons, it is imperative that health care professionals communicate effectively and utilize resources such as interpreter services.

Chapter 3 describes in more detail how to communicate with people who do not understand English, how to interact with interpreters, and which services are available when no interpreter is available. It is vital that interpreters be present who not only serve to verbally translate the conversation but who can also describe to you the cultural aspects and meanings of the person's situation.

CULTURE-RELATED CONCEPTS

Culture is a complex phenomenon that includes attitudes, beliefs, self-definitions, norms, roles, and values. It is also a web of communication, and much of culture is transmitted nonverbally through socialization or enculturation (Fig. 2.4).[35] *Socialization* or *enculturation* is the process of being raised within a culture and acquiring the norms, values, and behaviors of that group. According to the Department of Health and Human Services Office of Minority Health, a person's culture defines health and illness, identifies when treatment is needed and which treatments are acceptable, and informs a person of how symptoms are expressed and which symptoms are important.[39]

Culture has four basic characteristics: (1) *learned* from birth through the processes of language acquisition and socialization; (2) *shared* by all members of the same cultural group; (3) *adapted* to specific conditions related to environmental and technical factors and to the availability of natural resources; and (4) *dynamic* and ever changing.

Culture is a universal phenomenon, yet the culture that develops in any given society is unique, encompassing all the knowledge, beliefs, customs, and skills acquired by members of that society. However, within cultures some groups of people share different beliefs, values, and attitudes. Differences occur because of ethnicity, religion, education, occupation, age, and gender. When such groups function within a large culture, they are referred to as *subcultural groups.*

Many people think about race and ethnicity as a part of the concept of culture. Race reflects self-identification and

2.4

is typically a social construct referring to a group of people who share similar physical characteristics. The U.S. Census Bureau lists 15 racial categories for respondents to choose from: white, black (African American), American Indian or Alaskan native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, native Hawaiian, Guamanian or Chamorro, Samoan, other Pacific Islander, some other race, or more than one race. A growing number of respondents are identifying as more than one race, especially those in younger generations. An additional question asks respondents to identify whether they are of Hispanic origin. Hispanic origin includes the categories of Mexican, Puerto Rican, Cuban, and another Hispanic, Latino, or Spanish origin. People who self-identify as Hispanic can be of any racial category. For example, Dominicans typically identify as black Hispanics, whereas people from Argentina identify as white Hispanics. Because the terms *race* and *origin* cause confusion, the U.S. Census Bureau is considering changing the race and origin questions so that people can select all that apply, with racial categories and Hispanic origin combined in the same question.[8]

Race may be useful when determining disease prevalence, but does not typically refer to specific genetic or biologic characteristics that distinguish one group of people from another. Throughout the text, information on disease prevalence related to race is presented in the culture and genetics section of each chapter. As we learn more about the human genome, we may find that genetic variations become more important than overarching racial classifications.

Ethnicity refers to a social group that may possess shared traits, such as a common geographic origin, migratory status, religion, language, values, traditions or symbols, and food preferences. The ethnic group may have a loose group identity with few or no cultural traditions in common or a coherent subculture with a shared language and body of tradition. Similarly *ethnic identity* is one's self-identification with a particular ethnic group. This identity may be strongly adherent to one's country of origin or background or weakly identified.

Acculturation is the process of adopting the culture and behavior of the majority culture. During the late 1800s and early part of the 1900s when the United States experienced its greatest period of immigration, the expectation was that immigrants would take on the characteristics of the dominant culture, known as *assimilation.* Immigrants were discouraged from having a unique ethnic identity in favor of the nationalist identity.

2.5

The recent wave of immigrants in the latter part of the 20th century has developed different strategies of acculturation. Rather than solely relying on assimilation, new immigrants developed new means of forging identities between the countries of origin and their host country, such as "biculturalism" and "integration."[34] Assimilation is unidirectional, proceeding in a linear fashion from unacculturated to acculturated. However, biculturalism and integration are bidirectional and bidimensional, inducing reciprocal changes in both cultures and maintaining aspects of the original culture in one's ethnic identity (Fig. 2.5).

Those who emigrate to the United States from non-Western countries may find the process of acculturation, whether in schools or society, to be an extremely difficult and painful process. The losses and changes that occur when adjusting to or integrating a new system of beliefs, routines, and social roles are known as **acculturative stress,** which has important implications for health and illness.[9,10,36] When caring for patients, please be aware of the factors that contribute to acculturative stress, as defined in Table 2.1.[5]

TABLE 2.1 Dimensions of Acculturative Stress

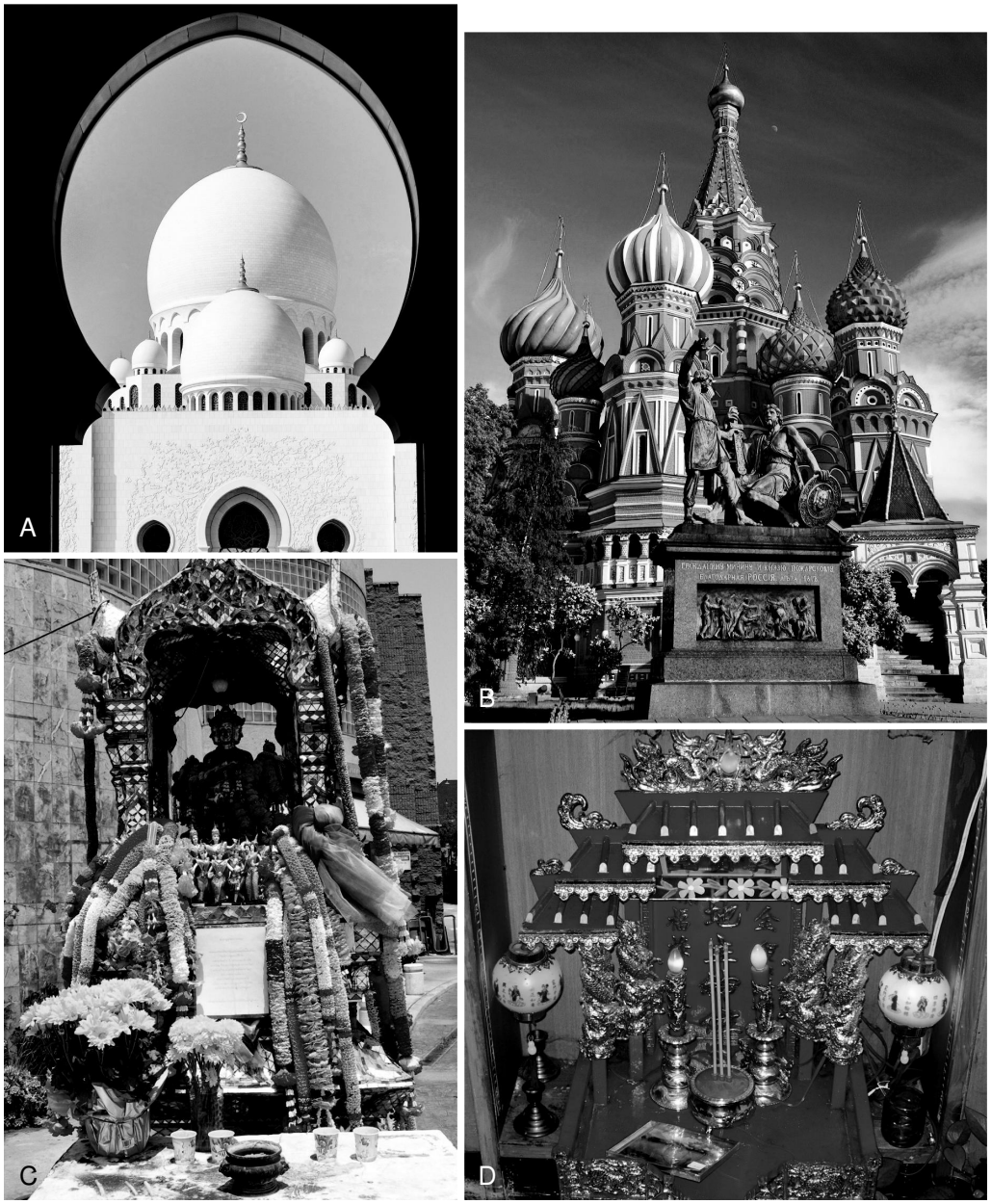
INSTRUMENTAL/ENVIRONMENTAL	SOCIAL/INTERPERSONAL	SOCIETAL
Financial	Loss of social networks	Discrimination/stigma
Language barriers	Loss of social status	Level of acculturation
Lack of access to health care	Family conflict	Political/historical forces
Unemployment	Family separation	Legal status
Lack of education	Intergenerational conflict	
	Changing gender roles	

Modified from Caplan, S. (2007). Latinos, acculturation, and acculturative stress: a dimensional concept analysis. *Policy Politics Nurs Pract, 8*(2), 93-106.

RELIGION AND SPIRITUALITY

Other major aspects of culture are **religion and spirituality. Spirituality** is a broader term focused on a connection to something larger than oneself and a belief in transcendence. On the other hand, **religion** refers to an organized system of beliefs concerning the cause, nature, and purpose of the universe, as well as the attendance of regular services.[19] Religion is a shared experience of spirituality or the values, beliefs, and practices into which people either are born or that they may adopt to meet their personal spiritual needs through communal actions, such as religious affiliation; attendance and participation in a religious institution, prayer, or meditation; and religious practices (Fig. 2.6). Some people define their spirituality in terms of religion, whereas others identify spirituality outside a formal religion.[2]

The Landscape Survey detailed statistics on religion in America.[29] The study found that religious affiliation in the United States is both diverse and extremely fluid. The number of people who say they are not affiliated with any particular faith increased from 16.1% in 2007 to 22.8% in 2015. The number of people affiliated with Christian denominations fell from 78.4% to 70.6%, whereas those who belong to non-Christian faiths increased from 4.7% to 5.9%. The percentage of people who affiliate with a Christian faith has dropped, but American Christians are becoming increasingly diverse.[29]



2.6 **A,** Mosque in Abu Dabai. **B,** Saint Basil's Cathedral. **C,** Thai spirit house. **D,** Buddhist shrine. (**C** and **D,** Spector, 2009.)

Although fewer individuals identify with a specific religion, spirituality assessment is important for all patients regardless of religious affiliation or nonaffiliation.

In times of crisis such as serious illness and impending death, spirituality may be a source of consolation for the person and his or her family. Religious dogma and spiritual leaders may exert considerable influence on the person's decision making concerning acceptable medical and surgical treatment such as vaccinations, choice of healer(s), and other aspects of the illness. Completion of a spiritual assessment is one component of a holistic patient assessment. Understanding a patient's spirituality can improve understanding of coping mechanisms, identify referral needs such as visits by a chaplain, identify social support after discharge, and open discussions about medical care (e.g., acceptance of certain treatments such as blood transfusion). Failure to assess spiritual needs has been shown to increase health care costs, especially at end of life, and unmet spiritual needs can lead to poor outcomes.[21] Religion and spirituality are associated with improved physical health, and attending to the religious and spiritual needs of patients is an important part of holistic patient care.[19]

HEALTH-RELATED BELIEFS AND PRACTICES

Healing and Culture

Health is defined as the **balance** of the person, both within one's being (physical, mental, or spiritual) and in the outside world (natural, communal, or metaphysical). It is a complex, interrelated phenomenon. Before determining whether cultural practices are helpful, harmful, or neutral, you must first understand the logic of the traditional belief systems coming from a person's culture and then grasp the nature and meaning of the health practice from the person's cultural perspective. Wide cultural variation exists in the manner in which certain symptoms and disease conditions are perceived, diagnosed, labeled, and treated.

Beliefs About Causes of Illness

Throughout history people have tried to understand the cause of illness and disease. Theories of causation have been formulated on the basis of ethnic identity, religious beliefs, social class, philosophic perspectives, and level of knowledge.[23] Many people who maintain traditional beliefs would define Health in terms of balance and a loss of this balance. This understanding includes the balance of mind, body, and spirit in the overall definitions of Health and Illness.

Disease causation may be viewed in three major ways: from a biomedical or scientific perspective, a naturalistic or holistic perspective, or a magicoreligious perspective.[22]

Biomedical

The **biomedical** or **scientific** theory of illness causation assumes that all events in life have a cause and effect. Among the biomedical explanations for disease is the germ theory, which holds that microorganisms such as bacteria and viruses cause specific disease conditions. Most educational programs for physicians, nurses, and other health care providers embrace the biomedical or scientific theories that explain the causes of both physical and psychological illnesses.[20]

Naturalistic

The second way in which people explain the cause of illness is from the **naturalistic** or **holistic** perspective, found most frequently among American Indians, Asians, and others who believe that human life is only one aspect of nature and a part of the general order of the cosmos. These people believe that the forces of nature must be kept in natural balance or harmony.

Some Asians believe in the **yin/yang theory,** in which health exists when all aspects of the person are in perfect balance.[25] Rooted in the ancient Chinese philosophy of *Tao,* the yin/yang theory states that all organisms and objects in the universe consist of yin and yang energy forces. The seat of the energy forces is within the autonomic nervous system, where balance between the opposing forces is maintained during health. Yin energy represents the female and negative forces such as emptiness, darkness, and cold, whereas yang forces are male and positive, emitting warmth and fullness. Foods are classified as hot and cold in this theory and are transformed into yin and yang energy when metabolized by the body. Yin foods are cold, and yang foods are hot. Cold foods are eaten with a hot illness, and hot foods are eaten with a cold illness. The yin/yang theory is the basis for *Eastern* or *Chinese* medicine.

Many Hispanic, Arab, and Asian groups embrace the **hot/cold theory** of health and illness, an explanatory model with origins in the ancient Greek humoral theory. The four humors of the body—blood, phlegm, black bile, and yellow bile—regulate basic bodily functions and are described in terms of temperature, dryness, and moisture. The treatment of disease consists of adding or subtracting cold, heat, dryness, or wetness to restore the balance of the humors. Beverages, foods, herbs, medicines, and diseases are classified as hot or cold according to their perceived effects on the body, not on their physical characteristics.

According to the hot/cold theory, the person is whole, not just a particular ailment. Those who embrace the hot/cold theory maintain that health consists of a positive state of total well-being, including physical, psychological, spiritual, and social aspects of the person.

Clinical case study: *Y.L. is a 30-year-old female who delivered her first child via uncomplicated vaginal delivery yesterday. You notice that she has not been drinking, refused her shower, and that her family has been providing much of the baby's care. In an effort to promote healing, you encourage her to go for a walk, provide fresh ice water, and talk to her about the importance of bonding. Y.L. continues to rest, drinks only warm beverages, and allows her family to provide care. You are concerned for Y.L.'s well-being and decide to speak with a colleague.*

You: I'm worried about Y.L. She isn't caring for her baby or herself, won't drink her water, and barely gets out of bed.

Colleague: Where is she from?

You: I'm not sure, but I think her family may have emigrated from China.

Colleague: It's common for the Chinese to believe in the hot/cold theory, wherein postpartum women need to avoid things that are cold and anything that might disrupt their yin. Have you asked her about her beliefs?

You: No. I didn't even think about it.

Colleague: We have pretty rigid standards of treatment in Western medicine, but we need to respect the beliefs of our patients. You should talk to her about her beliefs and any postpartum rituals we can support.

Magicoreligious

The third major way in which people explain the causation of Illness is from a **magicoreligious** perspective. The basic premise is that the world is an arena in which supernatural forces dominate.[16] The fate of the world and those in it depends on the action of supernatural forces for good or evil. Examples of magical causes of illness include beliefs in voodoo or witchcraft, whereas *faith healing* is based on religious beliefs.

Traditional Treatments and Folk Healers

All cultures have their own preferred lay or popular healers, recognized symptoms of ill health, acceptable sick role behavior, and treatments. In addition to seeking help from you as a biomedical/scientific health care provider, patients may also seek help from folk or religious healers (Fig. 2.7). Each culture has its own healers, most of whom speak the person's native tongue, make house calls, understand the person's cultural health beliefs, and cost significantly less than practitioners in the biomedical/scientific health care system. In some religions, spiritual healers may be found among the ranks of the ordained and official religious hierarchy. Spirituality is included in the perceptions of health and illness.

Hispanics may rely on *curandero(ra), espiritualista* (spiritualist), *yerbo(ba)* (herbalist), or *partera* (lay midwife). Blacks may mention having received assistance from a *houngan* (a voodoo priest or priestess), *spiritualist,* or "*old lady*" (an older woman who has successfully raised a family and who specializes in child care and folk remedies). American Indians may seek assistance from a *shaman* or a *medicine man* or *woman.* Asians may mention that they have visited *herbalists, acupuncturists,* or *bonesetters.* Among the Amish the term *braucher* refers to folk healers who use herbs and tonics in the home or community context. *Brauche,* a folk healing art, refers to sympathy curing, which is sometimes called *pow-wowing* in English.

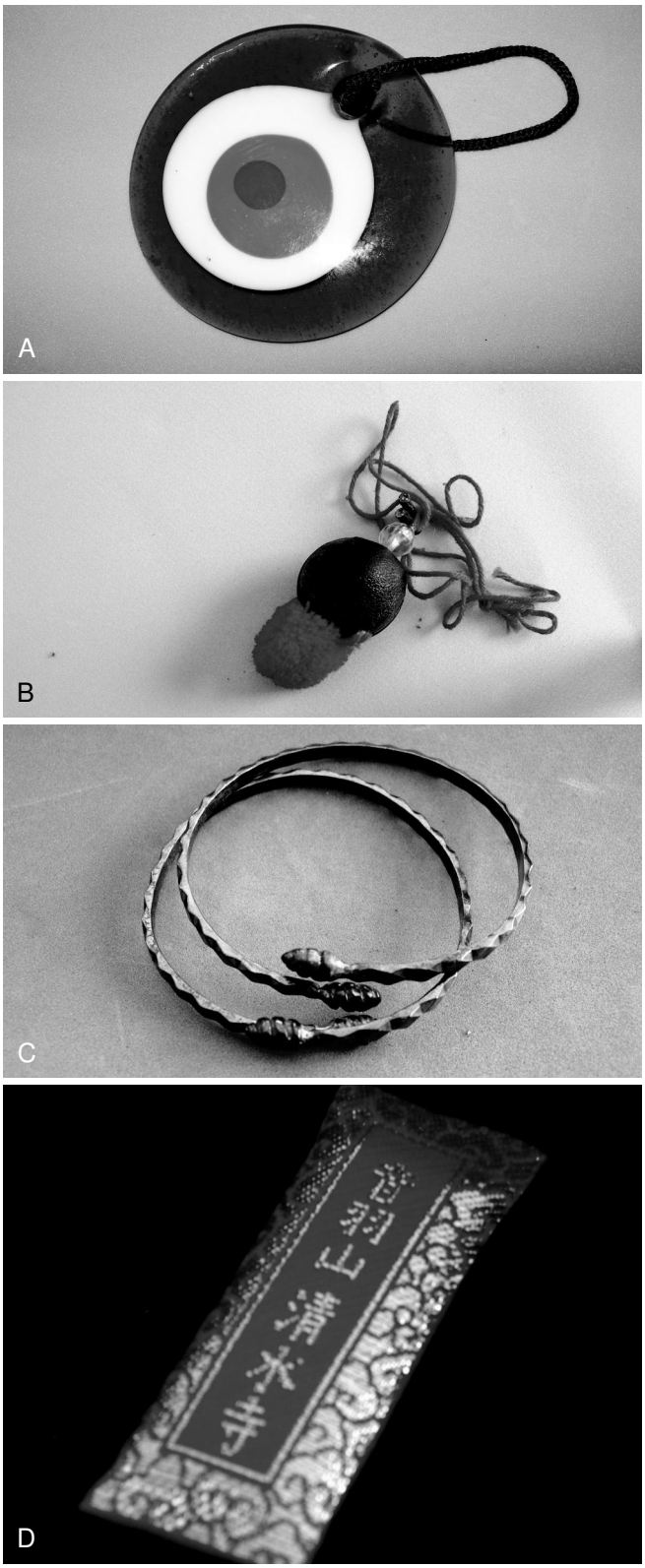
2.7 Aztec healer. (US DoD, 2015.)

Many cultures believe that the cure is incomplete unless healing of body, mind, and spirit is carried out. The division of the person into parts is itself a Western concept. If your patient refers to a lay healer that you are unfamiliar with or a practice you do not understand, ask for clarification. Be careful not to ask in a judgmental way that makes the person feel attacked for seeking help outside the medical community (e.g., "Why did you see a shaman instead of coming to the hospital?"). Instead ask in a way that communicates acceptance of their beliefs and allows for open communication (e.g., "Can you tell me more about your visit to the shaman? What did he/she recommend?").

The variety of healing beliefs and practices used by the many ethnocultural populations found in the United States far exceeds the limitations of this chapter. Fig. 2.8 presents samples of traditional amulets that may be seen in practice. In addition to folk practices, many other complementary healing practices exist. In the United States an estimated 38% of adults use some form of complementary therapy to treat an illness, including acupuncture, Ayurveda, biofeedback, chiropractic or osteopathic manipulation, deep-breathing exercises and guided imagery, diet-based therapies, homeopathy, hypnosis, meditation, tai chi, yoga, and traditional folk healers.[26] Furthermore, U.S. adults spend $30.2 billion out-of-pocket on visits to complementary and alternative medicine practitioners, to traditional healers, and for the purchase of related products each year.[26]

The availability of over-the-counter medications, the relatively high literacy level of Americans, the growing availability of herbal remedies, and the influence of the Internet and mass media in communicating health-related information to the general population have contributed to the high percentage of cases of self-treatment. Home treatments are attractive for their accessibility, especially compared with the inconvenience associated with traveling to a physician, nurse practitioner, or pharmacist, particularly for people from rural or sparsely populated areas. Furthermore, home treatment may mobilize the person's social support network and provide the sick person with a caring environment in which to convalesce.

A wide variety of alternative, complementary, or traditional interventions are gaining the recognition of health care professionals in the biomedical/scientific health care system. Acupuncture, acupressure, therapeutic touch, massage, therapeutic use of music, biofeedback, relaxation techniques, meditation, hypnosis, distraction, imagery, iridology, reflexology, and herbal remedies are examples of interventions that



2.8 Amulets. **A,** The glass blue eye from Turkey seen here is an example of an amulet that may be hung in the home. **B,** A seed with a red string may be placed on the crib of a baby of Mexican heritage. **C,** These bangles may be worn for protection by a person of Caribbean heritage. **D,** This small packet is placed on a crib or in the room of a baby of Japanese heritage.[35]

people may use either alone or in combination with other treatments. Many pharmacies and grocery stores routinely carry herbal treatments for a wide variety of common illnesses. The effectiveness of complementary and alternative interventions for specific health problems has been studied (see National Center for Complementary and Integrative Health at www.nccih.nih.gov).

DEVELOPMENTAL COMPETENCE

Illness during childhood may pose a difficult clinical situation. Children and adults have spiritual needs that vary according to the child's developmental level and the religious climate that exists in the family. Parental perceptions about the illness of the child may be partially influenced by religious beliefs. For example, some parents may believe that a transgression against a religious law is responsible for a congenital anomaly in their offspring. Other parents may delay seeking medical care because they believe that prayer should be tried first. Certain types of treatment (e.g., administration of blood; medications containing caffeine, pork, or other prohibited substances) and selected procedures may be perceived as *cultural taboos* (i.e., practices to be avoided by both children and adults).

Values held by the dominant U.S. culture such as emphasis on independence, self-reliance, and productivity influence the aging members of society. North Americans define people as old at the chronologic age of 65 years and then limit their work, in contrast to other cultures in which people are first recognized as being unable to work and then identified as being "old."

Older adults may develop their own means of coping with illness through self-care, assistance from family members, and support from social groups. Some cultures have attitudes and specific behaviors for older adults that include humanistic care and identification of family members as care providers.

Older immigrants who have made major lifestyle adjustments in their move from their homelands to the United States or from a rural to an urban area (or vice versa) may not be aware of health care alternatives, preventive programs, health care benefits, and screening programs for which they are eligible. These people also may be in various stages of *culture shock* (i.e., the state of disorientation or inability to respond to the behavior of a different cultural group because of its sudden strangeness, unfamiliarity, and incompatibility with the newcomer's perceptions and expectations).

TRANSCULTURAL EXPRESSION OF PAIN

To illustrate how symptom expression may reflect the person's cultural background, let us use an extensively studied symptom—pain. Pain is a universally recognized phenomenon, and it is an important aspect of assessment. It is a private, subjective experience that is greatly influenced by

cultural heritage. Expectations, manifestations, and management of pain are all embedded in a cultural context. The definition of pain, like that of health or illness, is culturally determined. The meaning of painful stimuli, the way people define their situations, and the impact of personal experience all help determine the experience of pain.

In addition to expecting variations in pain perception and tolerance, you also should expect variations in the expression of pain. While some patients will readily complain of pain, others will remain stoic and attempt to hide pain as much as possible. It is well known that people turn to their social environment for validation and comparison. A first important comparison group is the family, which transmits cultural norms to its children.

BECOMING A CULTURALLY COMPETENT PRACTITIONER

Cultural competency includes the attitudes, knowledge, and skills necessary for providing quality care to diverse populations.[4] The integration of cultural knowledge into day-to-day practice takes time because many practitioners in the health care system hesitate to adopt new ideas. Cultural competency does not come after reading a chapter or several books on this highly specialized area. It is complex and multifaceted, and many facets change over time. The areas of knowledge include sociology, psychology, theology, cultural anthropology, demography, folklore, and immigration history and policies. One must also have an understanding of poverty and environmental health. Cultural competency involves understanding your own culture and health. What cultural health practices do you use on a daily basis? What complementary or alternative therapies do you use?

One response to governmental mandates for cultural competency is the development of cultural care that describes professional health care as culturally sensitive, appropriate, and competent. There is a discrete body of knowledge, and much of the content is introduced in this chapter.

- *Culturally sensitive* implies that caregivers possess some basic knowledge of and constructive attitudes toward the diverse cultural populations found in the setting in which they are practicing.
- *Culturally appropriate* implies that the caregivers apply the underlying background knowledge that must be possessed to provide a given person with the best possible health care.
- *Culturally competent* implies that the caregivers understand and attend to the total context of the individual's situation, including awareness of immigration status, stress factors, other social factors, and cultural similarities and differences.[34]

Cultural care is the provision of health care across cultural boundaries; it considers the context both in which the patient lives and the situations in which the patient's health problems arise.[35] Each chapter in this text includes information necessary for the delivery of culturally appropriate care.

COMPLETING A CULTURAL ASSESSMENT

Lack of cultural knowledge has long been identified as a challenge to providing high-quality health care. Providing culturally congruent care is an integral part of providing holistic patient care. Many theories, frameworks, and models have been developed to facilitate understanding of culturally competent care. Instead of narrowly defining what to expect from a certain race or ethnic group, health care providers should complete a cultural assessment.

Categorical cultural knowledge related to language, food preferences, religion, and health care beliefs is limiting. Although health care providers have used this type of categorical information for years to inform practice, major limitations exist. The use of categorical knowledge can limit your perspective, putting you at risk for stereotyping.[15] As the United States continues to become increasingly diverse, health care providers are challenged to ignore previous assumptions and stereotypes in favor of asking the questions and completing a cultural assessment.

Cultural Self-Assessment

Although specific cultural self-assessment tools exist, a simple format is to think about and consider your culture: What influenced your life? Where is your family from? Do you or your family have cultural traditions? What led you to a career in health care? List your personal values, attitudes, and beliefs. Finally, answer the FICA questions presented in the upcoming section titled *Spiritual Assessment.* All too often, people state that they don't have a culture. Everyone has a culture, but individuals often don't think about the components of their culture in daily life. By purposefully exploring the areas of culture and understanding your personal history, you will develop cultural sensibility. **Cultural sensibility** is the "deliberate proactive behavior by health care providers who examine cultural situations through thoughtful reasoning, responsiveness, and discreet interactions."[15, p. 3]

Cultural Assessment

No one cultural assessment tool is identified as the gold standard of care. In addition to cultural assessment tools, there are a variety of theories, frameworks, and models of cultural competence. Each model identifies slightly different domains and perspectives on cultural competence, but all explicate the importance of completing a cultural assessment on every patient.

You should never assume an understanding of a person's culture; instead ask about cultural beliefs that may impact the care provided. Based on recommended domains from cultural experts,[17,24,32] the following is a list of domains you may consider assessing when caring for a patient. Please keep in mind that all domains may not be appropriate given your setting; however, each of the domains is an important component of understanding culture.

- Heritage. Country of ancestry; years in the United States, etc.

- Health practices. Use of a traditional healer; complementary/alternative therapies; preventative medicine; any practices that are unacceptable (e.g., blood transfusion)
- Communication. Primary language; preferred name and method of communication; use of touch as a communication strategy
- Family roles and social orientation. Who makes health care decisions within the family; family priorities; role of extended family; relationship status
- Nutrition. Any forbidden foods; fasting rituals; foods avoided or consumed during illness and in the peripartum period
- Pregnancy, birth, child-rearing. Number of children in the family; beliefs surrounding pregnancy; beliefs surrounding childbirth and child-rearing; special rituals after delivery
- Spirituality/religion. Religious affiliation; religious beliefs; holidays; spirituality assessment
- Death. Rituals in preparation for death; meaning of death; grieving
- Health providers. What is the role of the nurse or doctor; preference for same sex provider; any healers besides physicians and nurses

Although all areas may not be appropriate in all settings, consider the aforementioned main areas as you complete a cultural assessment on each patient. Asking each patient about cultural beliefs will increase your cultural competence while decreasing the potential for stereotyping based on previous experiences with a client from a similar background.

Spiritual Assessment

All too often a singular question—"Do you have any religious or spiritual preferences that we can support?"—is the extent of the spiritual assessment. This one question can be answered with a dichotomous yes/no, does not allow for open discussion, and sometimes leads to confusion. Instead of a singular question, health care professionals can use a brief spiritual assessment tool. A number of tools exist that allow health care providers to open a discussion of spiritual care, and no one tool is recommended above others.

One easy-to-use spiritual assessment tool is the FICA Spiritual History Tool, which serves as a guide for conversations. Health care professionals are encouraged to use FICA as a guide for fostering open dialogue and not as a checklist of questions to ask a patient. Recommended questions for each area are provided, but should be adapted to the situation. Speaking with a person who is at the end of life requires very different questions than does speaking with a healthy person during a wellness visit. FICA stands for *faith, importance/influence, community,* and *address/action.*

F- "Do you consider yourself spiritual or religious? Do you have spiritual beliefs, values, or practices that help you cope with stress?"

I- "What importance does your faith or belief have in your life? Have your beliefs influenced you in how you handle stress? Do you have specific beliefs that influence your health care decisions? If so, are you willing to share those with your health care team?"

C- "Are you part of a spiritual or religious community?" If so, how does this group support you? "Is there a group of people you really love or who are important to you?"

A- "How should I address these issues in your health care?"[31]

In health care settings you frequently encounter people who are searching for a spiritual meaning to help explain their illnesses or disabilities. Some health care providers find spiritual assessment difficult because of the abstract and personal

TABLE 2.2 Spirituality Assessment: The Brief RCOPE[a]

The following items deal with how you coped with a significant trauma or negative event in your life. There are many ways to try to deal with problems. These items ask which part religion played in what you did to cope with this negative event. Obviously, different people deal with things in different ways, but we are interested in how you tried to deal with it. Each item says something about a particular way of coping. We want to know to what extent you did what the item says: *how much or how frequently*. Don't answer on the basis of what worked or not—just whether or not you did it. Use these response choices.

Try to rate each item separately in your mind. Make your answers as true *for you* as you can.

1 = Not at all
2 = Somewhat
3 = Quite a bit
4 = A great deal

1. Looked for a stronger connection with God. _____
2. Sought God's love and care. _____
3. Sought help from God in letting go of my anger. _____
4. Tried to put my plans into action together with God. _____
5. Tried to see how God might be trying to strengthen me in this situation. _____
6. Asked forgiveness for my sins. _____
7. Focused on religion to stop worrying about my problems. _____
8. Wondered whether God had abandoned me. _____
9. Felt punished by God for my lack of devotion. _____
10. Wondered what I did for God to punish me. _____
11. Questioned God's love for me. _____
12. Wondered whether my church had abandoned me. _____
13. Decided the devil made this happen. _____
14. Questioned the power of God. _____

From Pargament, K., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: current psychometric status of a short measure of religious coping. *Religions* 2, 51-76.

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nature of the topic. The omission of questions about spiritual and religious practices can raise barriers to holistic care.

In addition to spiritual assessment tools, several well-validated questionnaires assess how a person is coping with loss, such as a serious illness. Perhaps the most well-known and widely used tool is the Brief RCOPE, a short 14-item assessment for use in clinical practice (Table 2.2).[28] The Brief RCOPE helps practitioners understand the patient's religious coping to enable them to integrate spirituality in treatment.[28] It examines whether a patient is using positive or negative religious coping. Positive religious coping mechanisms indicate that the person is strongly connected to a divine presence, is spiritually connected with others, and has a benevolent outlook on life, whereas negative religious coping methods reflect a spiritual struggle with one's self or with God. Illness may be attributed to God's punishment, to an act of the Devil, or totally within the hands of God. Just as positive religious coping has been linked to positive health, negative religious coping is associated with poor health outcomes.[28]

We need to understand a patient's cultural and religious beliefs because countless health-related behaviors are promoted by nearly all cultures and religions. Meditating, exercising and maintaining physical fitness, getting enough sleep, being willing to have the body examined, telling the truth about how one feels, maintaining family viability, hoping for recovery, coping with stress, being able to live with a disability, and caring for children are all related to one's core values and beliefs.

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CHAPTER 3

The Interview

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3.1

The interview is the first point of contact with a client[a] and the most important part of data collection. During the interview you collect **subjective data** (i.e., what the person says about himself or herself) (Fig. 3.1). Although the purpose of the interview isn't to collect **objective data** (i.e., what you obtain through physical examination), you will collect some objective data as you note the person's posture, physical appearance, ability to carry on a conversation, and overall demeanor. The interview is the best chance for a person to tell you what he or she perceives the health state to be. Once people enter the health care system, they relinquish some control, but during the interview the client remains in charge. The individual knows everything about his or her own health state, and you know nothing. Skilled interviewers are able to glean all necessary information while establishing a rapport with the client. Successful interviews allow you to:

1. Gather complete and accurate data about the person's health state, including the description and chronology of any symptoms.
2. Establish trust so that the person feels accepted and thus free to share all relevant data.
3. Teach the person about his or her health state.
4. Build rapport for a continuing therapeutic relationship.
5. Discuss health promotion and disease prevention.

[a]The term "client" is being used throughout this chapter to encompass the variety of settings in which you may encounter individuals where they are not considered patients, including the home setting.

Consider the interview a **contract** between you and your client. The contract concerns what the client needs and expects from health care and what you as a clinician have to offer. Your mutual goal is optimal health for the client. The terms of the contract include:

- Time and place of the interview and succeeding physical examination.
- Introduction of yourself and a brief explanation of your role.
- The purpose of the interview.
- How long it will take.
- Expectation of participation for each person.
- Presence of any other people (e.g., family, other health professionals, students).
- Confidentiality and to what extent it may be limited.
- Any costs to the client.

Although the person already may know some of this information through telephone contact with receptionists or the admitting office, the remaining points need to be stated clearly at the outset. Any confusion or unclear expectations can cause mistrust and resentment rather than the openness and trust required to facilitate the interview.

THE PROCESS OF COMMUNICATION

The vehicle that carries you and your client through the interview is communication. Communication is exchanging information so that each person clearly understands the other. If you do not understand one another, no communication has occurred.

It is challenging to teach the skill of interviewing because initially most people think it is common sense. They assume that if they can talk and hear, they can communicate. But much more than talking and hearing is necessary. Communication is based on behavior, conscious and unconscious, and all behavior has meaning.

Sending

Likely you are most aware of *verbal* communication—the words you speak, vocalizations, the tone of voice. *Nonverbal* communication is as important as verbal communication. This is your body language—posture, gestures, facial expression, eye contact, foot tapping, touch, even where you place your chair. Because nonverbal communication is under less conscious control than verbal communication, it may be more reflective of true feelings. A skilled interviewer will notice nonverbal behaviors and recognize the importance of potentially unconscious messages.

Receiving

Being aware of the messages you send is only part of the process. Your words and gestures must be interpreted by the receiver. Although you have a specific meaning in mind, the receiver may not understand the message as it was meant. The receiver uses his or her own interpretations of your words. These interpretations are based on past experiences, culture, and self-concept. Physical and emotional states also play a role in a person's interpretation. Your context and that of the receiver may not coincide, which can cause frustration and conflict. Your message can be sabotaged by the listener's bias or any preconceived notions. It takes mutual understanding by the sender and receiver to have successful communication.

Even greater risk for misunderstanding exists in the health care setting than in a social setting. The client's frame of reference is narrowed and focused on illness. The client usually has a health problem, and this factor emotionally charges your professional relationship. It intensifies the communication because the person feels dependent on you to get better.

Communication is one of the most important basic skills that can be learned and refined when you are a beginning practitioner. It is a tool, as basic to quality health care as the tools used in physical assessment. To maximize your communication skills, first you need to be aware of internal and external factors and their influence.

Internal Factors

Internal factors are those specific to you, the examiner. As you cultivate communication skills, you need to focus on the four inner factors of liking others, empathy, the ability to listen, and self-awareness.

Liking Others

One essential factor for a successful entry into a helping profession is a genuine liking of other people. This means a generally optimistic view of people—an assumption of strengths and a tolerance for weaknesses. An atmosphere of warmth and caring is necessary, and the client must believe that he or she is accepted unconditionally.

The respect for other people extends to respect for personal control over health and health care decision making. Your goal is to help clients be increasingly responsible for themselves. You wish to promote personal growth, and you have the health care resources to offer. Clients must choose how to apply resources and make health-related changes; you need to respect their choice to follow or disregard recommendations.

Empathy

Empathy means viewing the world from the other person's inner frame of reference while remaining you. It is a recognition and acceptance of the other person's feelings without criticism. Empathy is described as the ability to understand and be sensitive to the feelings of someone else. Empathy does not mean that you lose yourself in the other person at your own expense. By losing yourself, you cease to be useful. Empathy is the ability to recognize how someone perceives his or her world.

The Ability to Listen

Listening is not a passive role in the communication process; it is active and demanding. Listening requires complete and focused attention. You are not only hearing the person's words but also interpreting their meaning, asking follow-up questions, and ensuring a thorough understanding of what the person is telling you. If you are preoccupied with your own needs or those of other clients, you may miss important information. The needs of the person you are interviewing should be your sole concern.

Active listening is the route to understanding. Listen not only to what the person says but also to the way he or she says it. You also need to pay attention to what the person is not saying. Be aware of nonverbal communication and ask follow-up questions as appropriate, but do not interrupt. The story may not come out in the order you ask it, but it is important to allow the person to speak from his or her outline. As the person speaks, be aware of the way the story is told. Did he or she have any difficulty with language? What was the tone of voice? What is the person leaving out?

Self-Awareness

To effectively communicate with others, you must know yourself. Understanding your personal biases, prejudices, and stereotypes is an important part of developing your skills as an interviewer. By knowing your behaviors and responses, you become aware of how some unintentional actions can have a negative impact on your communication. You may have strong feelings about teen pregnancy, sexual orientation, or illicit drug use. By recognizing your biases and values, you can put them aside when dealing with people who may have a very different set of values. Part of your job as an interviewer is to recognize and set aside personal prejudices so that you can effectively care for all types of clients. If you recognize that you cannot put aside certain values, you may have to ask a colleague to step in and care for a client. For example, you are a devout Catholic who feels strongly that abortion is wrong. You are preparing to interview a 15-year-old who is 8 weeks pregnant. You know that she has made the appointment to discuss her options. If you are unable to put aside your belief that abortion is wrong and cannot counsel the young woman effectively, you may need to ask a colleague to complete the interview so that the young woman is presented with all options in an unbiased manner.

External Factors

Prepare the physical setting. The setting may be in a hospital room, an examination room in an office or clinic, or the person's home (where you have less control). In any location, optimal conditions are important to have a smooth interview.

Ensure Privacy

Aim for geographic privacy—a private room in the hospital, clinic, office, or home. If geographic privacy is unavailable, create "psychological privacy," using curtained partitions, but make sure that the person feels comfortable with the privacy provided. Privacy extends to ensuring that the client

is comfortable with the people in the room. Consider a teenager being interviewed before an annual physical. You will need to ask questions about risky behaviors, including alcohol, illicit drugs, and sexual behaviors. Do you think the teenager is going to be forthright and honest with a parent or guardian in the room? He or she may not be comfortable asking the parent or guardian to leave; however, it is your job to advocate for the teenager, which may include asking a parent or guardian to step out during the interview.

Refuse Interruptions

Most people resent interruptions except in cases of an emergency. You need to concentrate and establish rapport. An interruption can destroy in seconds what you have spent many minutes building up. If you anticipate an interruption, let the person know ahead of time. Inform colleagues of the interview and the need to minimize interruptions.

Physical Environment

- Set the room temperature at a comfortable level.
- Provide sufficient lighting so that you can see each other clearly, but avoid strong, direct lighting that may cause squinting.
- Secure a quiet environment. Turn off televisions, radios, and any unnecessary equipment.
- Remove distracting objects or equipment. It is appropriate to leave some professional equipment (otoscope/ophthalmoscope, blood pressure manometer) in view, but avoid clutter such as stacks of mail, other files, or your lunch. The room should advertise a trained professional.
- Place the distance between you and the client at 4 to 5 feet. Personal space is any space within 4 feet of a person. Encroaching on personal space can cause anxiety, but if you position yourself farther away, you may seem aloof and distant. The personal reaction bubble depends on a variety of factors, including culture, gender, and age. (See Table 3.1 for information on personal space.)
- Arrange **equal-status seating** (Fig. 3.2). Both you and the client should be comfortably seated, at eye level. Placing the chairs at 90 degrees is good because it allows the person either to face you or to look straight ahead from time to time. Make sure that you avoid facing a client across a desk because this creates a barrier. Most important, avoid standing. Standing does two things: (1) it communicates your haste, and (2) it assumes superiority. Standing makes you loom over the client as an authority figure. When you are sitting, the person feels some control in the setting.
- When interviewing a hospitalized bedridden person, arrange a face-to-face position, and avoid standing over him or her (Fig. 3.3). The person should not be staring at the ceiling but should have access to eye contact. Without eye contact the person loses the visual message of your communication.

TABLE 3.1 Functional Use of Space

ZONE	REMARKS
Intimate zone (0 to 1½ ft)	Visual distortion occurs Best for assessing breath and body odors
Personal distance (1½ to 4 ft)	Perceived as an extension of the self, similar to a bubble Voice moderate Body odors inapparent No visual distortion Much of physical assessment occurs at this distance
Social distance (4 to 12 ft)	Used for impersonal business transactions Perceptual information much less detailed Much of interview occurs at this distance
Public distance (12+ ft)	Interaction with others impersonal Speaker's voice must be projected Subtle facial expressions imperceptible

From Hall, E. (1963). Proxemics: the study of man's spatial relations. In Galdston, I. (Ed.). *Man's image in medicine and anthropology*. New York: International University Press, pp. 109-120.

3.2 Equal-status seating.

3.3 Avoid this position. (Potter et al., 2015.)

Dress

- The client should remain in street clothes during the interview except in an emergency. A hospital gown causes a power differential and may make the person feel exposed and uncomfortable. Establish rapport before asking the person to change into a gown.
- Your appearance and clothing should be appropriate to the setting and should meet conventional professional standards: a uniform or lab coat over conservative clothing, a name tag, and neat hair. Avoid extremes.

Note-Taking

Some use of history forms and note-taking may be unavoidable (see Fig. 3.2). When you sit down later to record the interview, you cannot rely completely on memory to furnish details of previous hospitalizations or the review of body systems. But be aware that excessive note-taking during the interview has disadvantages:

- It breaks eye contact too often.
- It shifts your attention away from the person, diminishing his or her sense of importance.
- Recording everything a person says may cause you to ask him or her to slow down, or the person may slow his or her tempo to allow for you to take notes. Either way, the client's natural mode of expression is lost.
- It impedes your observation of the client's nonverbal behavior.
- It is threatening to the client during the discussion of sensitive issues (e.g., alcohol and illicit drug use, number of sexual partners, or incidence of abuse).

Keep note-taking to a minimum and try to focus your attention on the person. Any recording you do should be secondary to the dialogue and should not interfere with the person's spontaneity. With experience you will rely less on note-taking. The use of standardized forms can decrease note-taking by providing check boxes for some of the information.

Electronic Health Record (EHR)

Direct computer recording of the health record has moved into nearly all health care settings. Mandates established by the federal government require health care organizations to utilize EHRs to improve quality and safety. The use of an EHR eliminates handwritten clinical data and provides access to online health education materials. Although computer entry facilitates data retrieval from numerous locations, this new technology poses problems for the provider-client relationship. EHR use improves documentation of biomedical information, but psychosocial and emotional information are not always captured.[13] Health care providers must capture biomedical, psychological, and emotional information in order to develop therapeutic relationships with clients. See Chapter 30 for more information about EHR.

Do not let the computer screen become a barrier between you and the client. Begin the interview as you usually would by greeting the person, establishing rapport, and collecting his or her narrative story in a direct face-to-face manner. Explain the computerized charting, and position the monitor so that the client can see it. Typing directly into the computer may ease entry of some sections of history such as past health occurrences, family history, and review of systems (see Chapter 4). Be aware that the client narrative, emotional issues, and complex health problems can only be addressed by the reciprocal communication techniques and client-centered interviewing presented in this chapter.

TECHNIQUES OF COMMUNICATION

Introducing the Interview

You may be nervous at the beginning of the interview. Keep in mind that the client probably is nervous as well. Keep the introduction short and formal. Address the person using his or her surname, and shake hands if appropriate. Unless the client directs you otherwise, avoid using the first name during the interview. Automatic use of the first name is too familiar for most adults and lessens dignity, but first names can be used with children and adolescents. You can also ask the person about his or her preference. If you are unsure how to correctly pronounce the name, ask. Interest in pronunciation shows respect.

Introduce yourself and state your role in the agency (if you are a student, say so). Give the reason for the interview:

> *"Mrs. Sanchez, I would like to talk about what caused you to come to the hospital today and get an update on your overall health status."*
>
> *"Mr. Craig, I want to ask you some questions about your previous medical history, family history, and any current complaints before we complete your physical examination."*

If the person is in the hospital, more than one health team member may be collecting a history. This repetition can be disconcerting because some people think that multiple clinicians asking the same questions indicates incompetence or a refusal to take the time to review the chart. Make sure that you indicate the reason for the interview to lessen the client's exasperation, and review notes from other health care team members before beginning the interview. Know which other team members the client has spoken to, and be able to tell him or her why your additional interview is necessary. Perhaps you are obtaining a full health history (including family history and review of systems) while your colleague obtained a focused history about the reason for seeking care.

After a brief introduction, ask an open-ended question (see the following section), and then let the person proceed. You do not need much friendly small talk to build rapport. This is not a social visit; the person wants to talk about some concern and wants to get on with it. You build rapport best by letting him or her discuss the concern early and by actively listening throughout the interview.

The Working Phase

The working phase is the data-gathering phase. Verbal skills for this phase include your ability to form questions appropriately and your responses to the answers given by the client. You will likely use a combination of open-ended and closed questions during the interview.

Open-Ended Questions

The **open-ended** question asks for narrative information. It states the topic to be discussed but only in general terms. Use it to begin the interview, to introduce a new section of questions, and whenever the person introduces a new topic.

"Tell me how I can help you."
"What brings you to the hospital?"
"You mentioned shortness of breath. Tell me more about that."

The open-ended question is unbiased; it leaves the person free to answer in any way. This type of question encourages the person to respond in paragraphs and give a spontaneous account in any order chosen. It lets the person express himself or herself fully.

As the person answers, make eye contact and actively listen. Typically he or she will provide a short answer, pause, and then look at you for direction on whether to continue. How you respond to this nonverbal question is key. If you pose new questions on other topics, you may lose much of the initial story. Instead lean forward slightly toward the client and make eye contact, looking interested. With your posture indicating interest, the person will likely continue his or her story. If not, you can respond to his or her statement with "Tell me more about…" or "Anything else?"

Closed or Direct Questions

Closed or **direct** questions ask for specific information. They elicit a one- or two-word answer, a "yes" or "no," or a forced choice. Whereas the open-ended question allows the client to have free rein, the direct question limits his or her answer.

Direct questions help you elicit specific information and are useful to fill in any details that were initially left out after the person's opening narrative. For example, you may be interviewing a client who suffers from migraines. Your initial open-ended comment of "Tell me about your headaches" elicited narrative information about the headaches. You follow up with a direct question—"Where are your headaches located?"—to obtain specific information that was initially left out of the narrative.

Direct questions are also useful when you need specific facts such as past medical history or during the review of systems. You need direct questions to speed up the interview. Asking all open-ended questions would be unwieldy and extend the interview for hours, but be careful not to overuse closed questions. Follow these guidelines:

1. Ask only one direct question at a time. Avoid bombarding the client with long lists: "Have you ever had pain, double vision, watering, or redness in the eyes?" Avoid double-barreled questions, such as "Do you exercise and follow a diet for your weight?" The client will not know which question to answer. And if the client answers "yes," you will not know which question he or she has answered.
2. Choose language the client understands. You may need to use regional phrases or colloquial expressions. For example, "running off" means *running away* in standard English, but it means *diarrhea* to natives of the Appalachian region.

Verbal Responses—Assisting the Narrative

You have asked the first open-ended question, and the client begins to answer. Your role is to encourage free expression while keeping the person focused. Your responses help the teller amplify the story.

Some people seek health care for short-term or relatively simple needs. Their history is direct and uncomplicated; for these people you may require only a subset of your full communication arsenal. Other people have a complex story, a long history of a chronic condition, or accompanying emotions that will require you to pull out all the stops during your interaction. There are nine types of verbal responses. The first five responses (facilitation, silence, reflection, empathy, clarification) involve your reactions to the facts or feelings that the person has communicated (Fig. 3.4). In the last four responses (confrontation, interpretation, explanation, summary), you start to express your *own* thoughts and feelings. In the first five responses the client leads; in the last four responses you lead. Study the array of possible responses in Table 3.2.

Ten Traps of Interviewing

The verbal responses presented in Table 3.2 are productive and enhance the interview. Now we will consider *traps,* which

3.4 Showing empathy.

TABLE 3.2 Examiner's Verbal Responses

RESPONSE	REASON FOR USE	EXAMPLE(S)
Client's Perspective		
Facilitation, general leads, minimal cues	• Encourages client to say more • Shows person you are interested	• *Mm-hmmm, go on, uh-huh* • Maintaining eye contact, shifting forward • Nodding *yes*
Silence	• Communicates that client has time to think • Silence can be uncomfortable for novice examiner, but interruption can make client lose his or her train of thought • Provides you with chance to observe client and note nonverbal cues	• Waiting for response without interruption • Sitting quietly; **don't fidget** • Counting silently 1 to 10
Reflection	• Echoes client's words by repeating part of what person has just said • Can help express feelings behind words • Mirroring client's words can help person elaborate on problem	• Client: *It's so hard having to stay in bed during my pregnancy. I have kids at home I'm worried about.* • Response: *You feel worried and anxious about your children?*
Empathy	• Names a feeling and allows its expression • Allows person to feel accepted and strengthens rapport • Useful in instances when client hasn't identified the feeling or isn't ready to discuss it	• Client (sarcastically): *This is just great! I own a business, direct my employees; now I can't even go to the bathroom without help.* • Response: *It must be hard—one day having so much control and now feeling dependent on someone else.* • Other responses include: *This must be very hard for you* or just placing hand on person's arm (see Fig. 3.4)
Clarification	• Useful when person's word choice is ambiguous or confusing • Summarize person's words, simplify the statement, and ensure that you are on the right track	• Response: *The heaviness in your chest occurs with walking up 1 flight of stairs or more than 1 block, but it stops when you rest. Is that correct?* • Client: *Yes, that's it.*
Examiner's Perspective		
Confrontation	• Clarifying inconsistent information • Focusing client's attention on an observed behavior, action, or feeling	• *You look sad,* or *You sound angry.* • *Earlier you said that you didn't drink, but just now you said you go out every night after work for 1-2 beers.* • *When I press here, you grimace, but you said it doesn't hurt.*
Interpretation	• Links events, makes associations, and implies cause • Not based on direct observations but instead on inference or conclusion • Your interpretation may be incorrect but helps prompt further discussion	• *It seems that every time you feel the stomach pain, you have some type of stress in your life.* • Client: *I don't want any more treatment, but I can't seem to tell the doctor I'm ready to stop.* • Response: *Could it be that you're afraid of her reaction?*
Explanation	• Informing person • Sharing factual and objective information	• *You order your dinner from the menu provided, and it takes approximately 30 minutes to arrive.* • *You may not eat or drink for 12 hours before your blood test because the food may change the results.*
Summary	• Condenses facts and validates what was discussed during the interview • Signals that termination of interview is imminent • Both client and examiner should be active participants	• Review pertinent facts • Allow client time to make corrections

are nonproductive verbal and nonverbal messages. Because you want to help your client, it is easy to fall into the traps and send negative verbal messages that may do the opposite of what you intended by cutting off communication. Be aware of the following traps, and work to avoid them as you establish your communication style.

1. Providing False Assurance or Reassurance

A pregnant woman says, "I've been spotting on and off all day, and I haven't felt the baby kick. I just know I'm going to miscarry." Your automatic response may be to provide reassurance, "Don't worry. I'm sure you and the baby will be fine." Although this helps relieve your anxiety and gives you the sense that you have provided comfort, it actually trivializes the woman's anxiety and closes off communication. You have also just promised something that may not be true, which can diminish rapport. Consider these responses:

"You're really worried about your baby, aren't you?"
"It must be hard to wait for the doctor. Is there anything I can get you or anything that you'd like to talk about?"

These responses acknowledge the feeling and open the door for more communication.

A genuine, valid form of reassurance does exist. You *can* reassure clients that you are listening to them, that you understand them, that you have hope for them, and that you will take good care of them.

Client: "I feel so lost here since they transferred me to the medical center. My family lives too far away to visit, and no one here knows me or cares."
Response: "I care what happens to you. I will be here all day today and for the next 3 days. Please call if you need anything."

This type of reassurance makes a commitment to the client, and it can have a powerful impact.

2. Giving Unwanted Advice

It is important as a health care provider to recognize when giving advice is warranted and when it should be avoided. People often seek health care because they want professional advice. A parent may ask how to care for a child with chickenpox, or an older man may ask if it is appropriate to receive a pneumonia vaccine. These are straightforward requests for information, and you respond by providing the appropriate information.

But if advice is based on a hunch or feeling or is your personal opinion, then it is most likely inappropriate. Consider a young woman who has just met with her physician about her infertility issues: "Dr. Compton just told me I have to have surgery and that, if I don't, I won't be able to get pregnant. What would you do?" If you provide an answer, especially if the answer begins with "If I were you …" you would be falling into a trap. You are not your client and therefore cannot make decisions for her. Providing an answer shifts accountability to you instead of the client. The woman must work out her own decision. So what do you do?

Response: What are your concerns about the recommendation?
Woman: I'm terrified of being put to sleep. What if I don't wake up?

Now you know her real concern and can help her deal with it. She will have grown in the process and may be better equipped to make her decision.

When asked for advice, other preferred responses are:

"What are the pros and cons of _____ [this choice] for you?"
"What is holding you back?"

Although it is quicker just to give advice, take the time to involve the patient in a problem-solving process.

3. Using Authority

"Your doctor/nurse knows best" is a response that promotes dependency and inferiority. You effectively diminish the client's concerns with one short sentence, and you cut off communication. Using authority should be avoided. Although you may have more professional knowledge than the client, you both have equally important roles since the client must make the final decision about his or her health.

4. Using Avoidance Language

People use euphemisms instead of discussing unpleasant topics. For example, people use "passed on" or "has gone to a better place" to avoid the reality of dying. Using euphemisms promotes the avoidance of reality and allows people to hide their feelings. Not talking about uncomfortable topics doesn't make them go away but instead makes them even more frightening. The best way to deal with frightening or uncomfortable topics is by using direct language.

5. Distancing

Distancing is the use of impersonal speech to put space between a threat and the self: "There is a lump in *the* left breast." By using "the" instead of "your," you are allowing the woman to deny any association with her diseased breast and protect herself from it. Health professionals use distancing to soften reality, but in actuality it may communicate that you are afraid of the procedure or disease. Clients use distancing to avoid admitting that they have a problem: "My doctor told me that the prostate was enlarged." Using specific language and blunt terms indicates that you are not fearful of the disease or procedure and may decrease anxiety and help the client cope with the reality of the situation.

6. Using Professional Jargon

The medical profession is fraught with jargon that sounds exclusionary and paternalistic. It is important to adjust your vocabulary to ensure understanding without sounding condescending. Just because your client uses medical jargon,

don't assume that he or she understands the correct meaning. Some people think "hypertensive" means *tense.* This misunderstanding may cause them to take their medication only when they are feeling tense and stressed instead of taking it all the time. Misinformation must be corrected immediately to ensure compliance.

7. Using Leading or Biased Questions

Asking a client, "You don't smoke, do you?" or "You don't ever have unprotected sex, correct?" implies that one answer is "better" than another. If the client wants to please you, he or she will either answer in a way corresponding to your values or feel guilty when he or she must admit the other answer. The client feels that he or she risks your disapproval by not answering the question "correctly." If the client feels dependent on you for care, he or she won't want to alienate you and may not answer truthfully. Make sure that your questions are unbiased, and do not lead clients to a certain "correct" answer. For example, you might instead ask, "Do you smoke?" or "When you have sexual intercourse, do you use protection?"

8. Talking Too Much

Some examiners positively associate helpfulness with verbal productivity. If the air has been thick with their oratory and advice, these examiners leave thinking that they have met the client's needs. Just the opposite is true. Eager to please the examiner, the client lets the professional talk at the expense of his or her need to express himself or herself. A good rule for every interviewer is to listen more than you talk.

9. Interrupting

When you think you know what the client is going to say next, it is easy to cut him or her off and finish the statement. Unfortunately you are not proving that you are clever, but you are signaling impatience or boredom. Related to interruption is preoccupation with yourself. As the client speaks, you may be thinking about what to say next. If you are focused on your next statement instead of his or her statements, you are unable to fully understand what the person is saying. The goal of the interview is to include two people listening and two people speaking. Leave at least a second of space between the end of the client speaking and your next statement. This ensures that the client has finished.

10. Using "Why" Questions

Children ask why questions constantly. Why is the sky blue? Why can't I have a cookie for dinner? Their motive is an innocent search for information. The adult's use of "why" questions usually implies blame and condemnation; it puts the person on the defensive. Consider your use of "why" questions in the health care setting. "Why did you take so much medication?" Or "Why did you wait so long before coming to the hospital if you were having chest pain?" The use of a "why" question makes the interviewer sound accusatory and judgmental. By using a "why" question, the client must produce an excuse to rationalize his or her behavior. To avoid this trap, say, "I see you started to have chest pain early in the day. What was happening between the time the pain started and the time you came to the emergency department?"

Nonverbal Skills

As a novice interviewer you may be focused on what the client says, but listening with your eyes is just as important as listening with your ears. Nonverbal modes of communication include physical appearance, posture, gestures, facial expression, eye contact, voice, and touch. They are important in establishing rapport and conveying information.[1] They provide clues to understanding feelings. When nonverbal and verbal messages are congruent, the verbal message is reinforced. When they are incongruent, the nonverbal message tends to be the true one because it is under less conscious control.

Physical Appearance

We have all noted people who simply look sick without specific signs that lead to a precise diagnosis. As a health care provider, it is important that you consider physical appearance when you first encounter a client. Inattention to dressing or grooming suggests that the person is too sick to maintain self-care or has an emotional dysfunction such as depression. Choice of clothing also sends a message, projecting such varied images as role (student, worker, or professional) or attitude (casual, suggestive, or rebellious).

You are concerned with the client's image, and he or she is just as concerned with yours. Your appearance sends a message to the client. Professional dress varies among agencies and settings. Professional uniforms can create a positive or a negative image. Whatever your personal choice in clothing or grooming is, the aim should be to convey a competent, professional image and should follow agency guidelines (Fig. 3.5).

Posture

On beginning the interview, note the client's position. An open position with extension of large muscle groups shows relaxation, physical comfort, and a willingness to share information. A closed position with arms and legs crossed looks defensive and anxious. Changes in posture during the interview can also suggest a different comfort level with new topics. For example, if your client began the interview in an open posture but immediately assumes a closed posture when asked about his or her sexuality, he or she may be uncomfortable with the new topic.

Make sure that you are aware of your own posture. Assuming a calm, relaxed posture conveys interest. On the other hand, standing and hastily filling out forms while peeking at your watch communicates that you are busy with many more important things than interviewing this client. Even when your time is limited, it is important to appear unhurried. Sit down, even if it is only for a few minutes, and look as if nothing else matters except this client. If you are aware of a potential emergency that will require interruption, let the client know when you enter the room.

3.5

Gestures

Gestures send messages; therefore make sure that you are aware of your own gestures while also noting those of the client. Nodding the head or openly turning out the hand shows acceptance, attention, or agreement, whereas wringing the hands or picking the nails often indicates anxiety. Hand gestures can also reinforce descriptions of pain. When describing crushing substernal chest pain, the client often holds a fisted hand in front of the sternum. Sharply localized pain is often indicated by using one finger. Movements such as bouncing a leg, clicking a pen, playing with hair, or drumming fingers can distract the client and cause him or her to lose focus. Make sure that you know if you tend to fidget, and work on controlling that urge during interviews.

Facial Expression

Typically the face and facial expression are some of the first things we notice when we meet someone. The face reflects our emotions and conditions. As an interviewer it is important to note your client's facial expression. Does it match what he or she is saying, or is it incongruous?

As you pay attention to the client's expression, it is equally important that you are aware of your own facial expression. Your expression should reflect a person who is attentive, sincere, and interested. Avoid expressions that may be construed as boredom, disgust, distraction, criticism, or disbelief. A negative facial expression can severely damage your rapport with the client and may lead him or her to stop communicating.

Eye Contact

Lack of eye contact suggests that the person is shy, withdrawn, confused, bored, intimidated, apathetic, or depressed. This applies to examiners too. You should aim to maintain eye contact, but do not stare at the person. Do not have a fixed, penetrating look but rather an easy gaze toward the person's eyes, with occasional glances away. One exception to this is when you are interviewing someone from a culture that avoids direct eye contact.

Voice

Although spoken words have meaning, it is important that you are keenly aware of the tone of your voice and that of the client. Meaning comes not only from the words spoken, but also from the tone of voice, the intensity and rate of speech, the pitch, and any pauses. The tone of voice may show sarcasm, disbelief, sympathy, or hostility. People who are anxious often speak louder and faster than normal. A soft voice may indicate shyness or fear, whereas a loud voice may indicate that the person is hearing impaired.

Even the use of pauses conveys meaning. When your question is easy and straightforward, a client's long, unexpected pause indicates that the person is taking time to think of an answer. This raises some doubt as to the honesty of the answer or whether the client heard the question. When unusually frequent and long pauses are combined with speech that is slow and monotonous and a weak, breathy voice, it indicates depression.

Touch

The meaning of physical touch is influenced by the person's age, gender, cultural background, past experience, and current setting. The meaning of touch is easily misinterpreted. In most Western cultures physical touch is reserved for expressions of love and affection or for rigidly defined acts of greeting. Do not use touch during the interview unless you know the person well and are sure how it will be interpreted.

In summation, an examiner's nonverbal messages that show attentiveness and unconditional acceptance are productive and help build rapport. Defeating, nonproductive nonverbal behaviors are those of inattentiveness, authority, and superiority (Table 3.3).

Closing the Interview

The session should end gracefully. An abrupt or awkward closing can destroy rapport and leave the person with a negative impression of the interaction. To ease into the closing, ask the person:

"Is there anything else you would like to mention?"
"Are there any questions you would like to ask?"
"We've covered a number of concerns today. What would you most like to accomplish?"

This gives the person the final opportunity for self-expression. Once this opportunity has been offered, you will need to make a closing statement that indicates that the end of the

TABLE 3.3 Nonverbal Behaviors of the Interviewer

Positive	Negative
Appropriate professional appearance	Appearance objectionable to client
Equal-status seating	Standing above the client
Close proximity to client	Sitting behind desk, far away, turned away
Relaxed, open posture	Tense posture
Leaning slightly toward person	Slouched in chair
Occasional facilitating gestures	Critical or distracting gestures: pointing finger, clenched fist, finger-tapping, foot-swinging, looking at watch
Facial animation, interest	Bland expression, yawning, tight mouth
Appropriate smiling	Frowning, lip biting
Appropriate eye contact	Shifty, avoiding eye contact, focusing on notes
Moderate tone of voice	Strident, high-pitched tone
Moderate rate of speech	Rate too slow or too fast
Appropriate touch	Too frequent or inappropriate touch

interview is imminent, such as, "Our interview is just about over." At this point no new topics should be introduced, and no unexpected questions should be asked. This is a good time to give your **summary** of what you have learned during the interview. The summary is a final statement of what you and the client agree the health state to be. It should include positive health aspects, any health problems that have been identified, any plans for action, and an explanation of the subsequent physical examination. As you part from clients, thank them for the time spent and for their cooperation.

DEVELOPMENTAL COMPETENCE

Interviewing the Parent or Caregiver

When your client is a child, you must build rapport with two people—the child and the accompanying caregiver. Greet both by name, but with a younger child (1 to 6 years old) focus more on the caregiver. Ignoring the child temporarily allows him or her to size you up from a safe distance. The child can use this time to observe your interaction with the caregiver. If the child sees that the caregiver accepts and likes you, he or she will begin to relax (Fig. 3.6).

Begin by interviewing the caregiver and child together. If any sensitive topics arise (e.g., the parents' troubled relationship or the child's problems at school or with peers), explore them later when the caregiver is alone. Provide toys to occupy a young child as you and the caregiver talk. This frees the caregiver to concentrate on the history and gives you information about the child's level of attention span and ability for independent play. Throughout the interview observe the caregiver-child interaction.

For younger children, the parent or caregiver will provide all or most of the history. Thus you are collecting the child's health data from the caregiver's frame of reference, which typically is considered reliable. Most caregivers have the child's well-being in mind and will cooperate with you to enhance it. Bias can occur when caregivers are asked to describe the child's achievements or when their ability to provide proper care seems called into question. For example, if you say "His fever was 103, and you didn't bring him in?" you are implying a lack of skills, which puts the caregiver on the defensive and increases anxiety. Instead use open-ended questions that increase description and defuse threat, such as "What happened when the fever went up?"

A parent with more than one child has more than one set of data to remember. Be patient as the parent sorts through his or her memory to pull out facts of developmental milestones or past history. A comprehensive history may be lacking if the child is accompanied by a family friend or daycare provider instead of the primary caregiver.

When asking about developmental milestones, avoid judgmental behavior or inferring that the behavior occurred late. Parents are understandably proud of their child's achievements and are sensitive to insinuations that these milestones occurred late. "So he didn't say any words until he was 15 months old? Did you take him to speech therapy?" Instead consider saying, "I see that Jon began speaking when he was 15 months old. How is his speech progressing now that he is 2 years old?"

Always refer to the child by name and ensure that he or she is included in the interview as appropriate. Refer to the parent by his or her proper surname instead of "Mom" or "Dad." Remember not to make any assumptions. The person

3.6